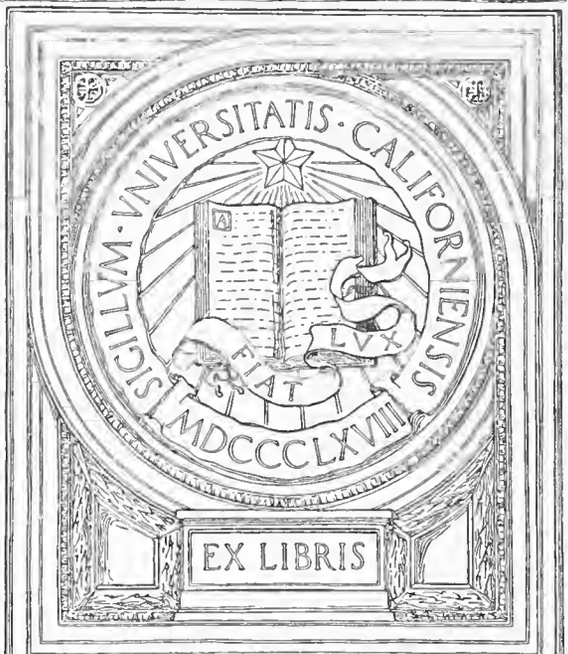
UNIVERSITY OF CALIFORNIA
SAN FRANCISCO MEDICAL CENTER
LIBRARY





Digitized by the Internet Archive
in 2017 with funding from
The National Endowment for the Humanities and the Arcadia Fund

https://archive.org/details/hawaiimedicaljou26unse

SEPTEMBER — OCTOBER 1966

# HAWAII Medical Journal

U.C. MEDICAL CENTER LIBRARY
OCT 25 1966
San Francisco 94122

U.C. MEDICAL CENTER
SAN FRANCISCO

Volume 26 — Number 1

224874

# a sea of trouble for pollen-sensitive patients



Artist's depiction of Dwarf Ragweed
*(Ambrosia elatior L.)* and pollen

# Benadryl®

(diphenhydramine hydrochloride)

PARKE-DAVIS

## for control of allergic distress

The pink capsule with the white band is a trademark of Parke, Davis & Company.

- *antihistaminic action* relieves sneezing, nasal congestion, pruritus, and lacrimation
- *antispasmodic action* alleviates bronchial and gastrointestinal spasm.

*Precautions:* Persons who have become drowsy on this or other antihistamine-containing drugs, or whose tolerance is not known, should not drive vehicles or engage in other activities requiring keen response while using this product. Hypnotics, sedatives, or tranquilizers if used with BENADRYL should be prescribed with caution because of possible additive effect. Diphenhydramine has an atropine-like action which should be considered when prescribing BENADRYL.
*Side Effects:* Side reactions, commonly associated with antihistaminic therapy and generally mild, may affect the nervous, gastrointestinal, and cardiovascular systems. Most frequent reactions are drowsiness, dizziness, dryness of the mouth, nausea, and nervousness. BENADRYL is available in Kapseals® of 50 mg. and Capsules of 25 mg.

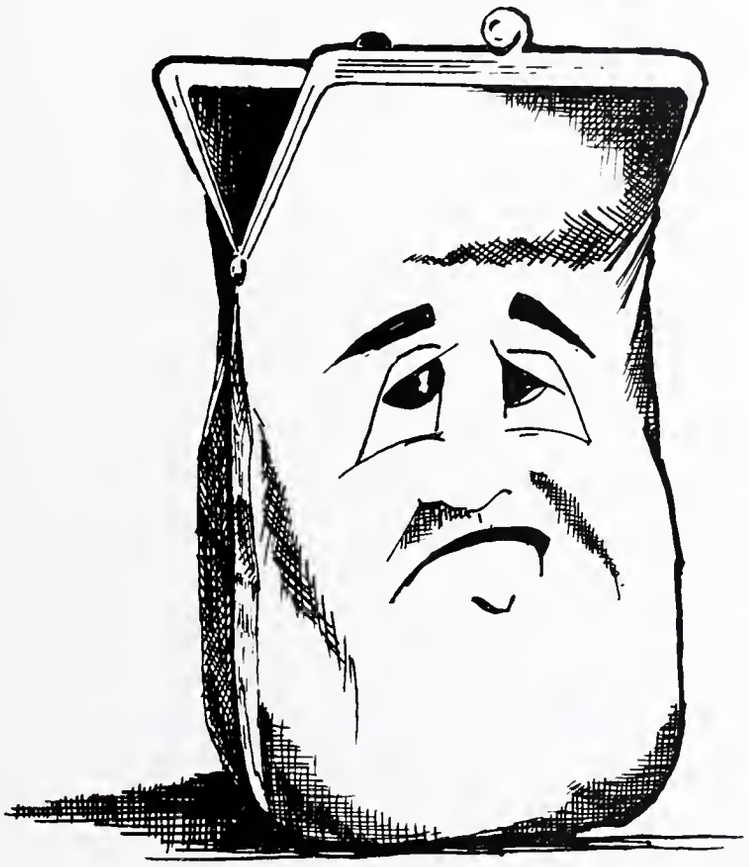
PARKE-DAVIS

*PARKE, DAVIS & COMPANY, Detroit, Michigan 48232*

1866 1966 100th ANNIVERSARY

00566

# SUFFERING FROM POCKETBOOK ANEMIA?



***A Strong Dose Of "Tax Shelter" May Be The Cure!***

If you're concerned about keeping more of your earned income you'll be wise to look into tax shelter. Let Shirley Olds, Realtors provide the medicine to cure your pocket-book anemia.

They're specialists in tax shelter.

*Shirley Olds, Inc.*
*REALTORS*
*708 Ward Avenue / Phone 506-578*

HAWAII MEDICAL JOURNAL

*Published Bi-Monthly by the* HAWAII MEDICAL ASSOCIATION (Incorporated in 1856 under the Monarchy), 510 S. Beretania St., Honolulu, Hawaii 96813 • *Editor,* HARRY L. ARNOLD, JR., M.D. • *News Editor,* HENRY N. YOKOYAMA, M.D. • *Managing Editor,* LEE MCCASLIN

VOLUME 26, NUMBER 1 • SEPT.-OCT., 1966 • $6.00 A YEAR, $1.00 A COPY

# The Hawaii Medical Association

## Officers 1966-1967

President • THEODORE T. TOMITA, *Honolulu*
President-Elect • B. A. RICHARDSON, *Honolulu*
Past President • O. D. PINKERTON, *Honolulu*
Secretary • R. VARIAN SLOAN, *Honolulu*
Treasurer • HERBERT Y. H. CHINN, *Honolulu*

County Presidents

Hawaii County • ED B. HELMS, *Hilo*
Honolulu County • JOHN J. LOWREY, *Honolulu*
Kauai County • Y. MIYASHIRO, *Waimea*
Maui County • KENNETH HALING, *Kahului*

Delegate to A.M.A. • RICHARD D. MOORE, *Honolulu*
Alt. Delegate to A.M.A. • GEORGE H. MILLS, *Honolulu*

## Councillors 1966-1967

Maui • JOSEPH E. ANDREWS
Honolulu • GROVER H. BATTEN
Honolulu • BERNARD W. D. FONG
Honolulu • ANDREW C. IVY, JR.
Hawaii • ROBERT M. MIYAMOTO
Kauai • SAMUEL R. WALLIS

## Officers—County Societies—1966

| HAWAII | | HONOLULU |
|---|---|---|
| ED B. HELMS • | President | • JOHN J. LOWREY |
| ETTA WRIGHT BEST • | Vice President | • GEORGE H. MILLS |
| CHARLES H. BELCHER • | Secretary | • KEITH F. O. KUHLMAN |
| PAUL CALDWELL • | Treasurer | • HERBERT Y. H. CHINN |

| KAUAI | | MAUI |
|---|---|---|
| Y. MIYASHIRO • | President | • KENNETH HALING |
| SAMUEL WALLIS • | Vice President | • BILLIE FERN STROTHER |
| JAMES P. WARNER • | {Secretary} {Treasurer} | • SAKAE UEHARA |

The JOURNAL may not be held responsible for opinions expressed in papers discussions, communications, or advertisements. The advertising policy of the HAWAII MEDICAL JOURNAL is governed by the rules of the Council on Drugs of the American Medical Association. The right is reserved to reject material submitted for editorial or advertising columns. All material for publication must be in the hands of the editor on or before the 10th day of the month preceding publication date. Reprints of original articles will be supplied at actual cost, provided request is attached to manuscript or made in sufficient time before publication. A reasonable number of cuts and illustrations accompanying an article will be accepted for printing. The right is reserved to ask the author to bear cost of these when it is found necessary to do so.

Copyright, 1966, by the Hawaii Medical Association, Honolulu, Hawaii. Entered as second class matter, October 17, 1941, at the Post Office in Honolulu, Hawaii, under the Act of August 24, 1912. Office of Publication: Mabel L. Smyth Memorial Building, 510 S. Beretania St., Honolulu, Hawaii 96813.




The members of The Hawaii Medical Association are most grateful to Eli Lilly and Company for relinquishing its front cover position for this commemorative issue.

HAWAII MEDICAL JOURNAL

# Contents

Volume 26, Number 1, Sept.-Oct. 1966

**Articles**

*Tribute to Harry Loren Arnold, Jr., on the 25th anniversary of the H.M.J.—1941–1966* 25
Hugh Lytle

*Paradise Practice Caps 1 Sig. Take With Grain of Salt* 31
Robert and Marie Faus, M.D.'s

*Progress in Dermatology* 34
Harold M. Johnson, M.D.

*Surgical Advances in Hawaii During the Past 25 Years* 35
Joseph E. Strode, M.D.

**Editorials**

*Reppunzel, Reppunzel, Put Up Your Hair* 39
*The Declaration of Helsinki* 40
*Typhoid—Remembrance of Things Past* 40
*The Political Credo of a Physician* 41

**Features**

*Book Reviews* 45
*Correspondence* 7
*County Society Reports* 48
*Hawaii Academy of General Practice* 42
*In Memoriam—Doctors of Hawaii—LXIII* 44
*New Members* 48
*Notes and News* 46
*Poetry: Loopus Benignus or The Sperm That Turned* 35
*President's Page* 38
*This is What's New* 43

**Hawaii Technologists' Bulletin**

*President's Report* 52
*Educational Reference Committee* 52

# Correspondence

## From the Mainland

To the Editor:

The American Academy of Dermatology sends compliments to its immediate past Vice-president, Dr. Harry L. Arnold, Jr., on the occasion of the marking of the twenty-fifth anniversary of his editorship of the Hawaii Medical Journal. The President is particularly happy to have the opportunity to greet you on this occasion because of our long-time friendship with you, a man of many interests and talents, and to acknowledge with appreciation the benefits I have gained from this association. The American Academy of Dermatology salutes you. During many years as active member, teacher, and officer of this organization, you have contributed much to the high status of American Dermatology. Aloha!

Herman Beerman, M.D., President
American Academy of Dermatology, Inc.

To the Editor:

I was pleased to learn that a communication from the Editorial Board of *JAMA* would be welcome in the medical journal furthest from these headquarters. The Hawaii Medical Journal is to be congratulated in having your services for one-quarter of a century. This is considerably longer than most tenures for medical journals but the reason is obvious. Your great interest in medical writing is commensurate with your skill in the treatment of cutaneous maladies and is as durable.

I am not sure that cake will be allowed at the Anniversary Luau, but if it is, I hope that someone will partake of it for me in your honor, the glistening domed editor whose intellect shines from within, matching the luster on the pate.

John H. Talbott, M.D., Editor
*Journal of the American Medical Association*

To the Editor:

The opportunity of honoring you, my young friend, who are nevertheless so much my editorial senior, is a privilege and a challenge. Not only does the beginning of your editorship of the Hawaii Medical Journal precede my own and that of all your other contemporaries with any individual periodical, but you are the actual parent of your publication, whereas my own relation to the *New England Journal of Medicine* is one of mutual adoption.

My friendship with you has had its special rewards, too, for you read our local *Journal* carefully, with pencil poised, note the errors and sadly pass on the information almost unhesitatingly.

So on with the next quarter century!

With warmest greetings.

Joseph Garland, M.D., Editor
*New England Journal of Medicine*

## From Our Past HMA Presidents

To the Editor:

It has come to my attention that the Hawaii Medical Journal will soon celebrate its 25th year of significant service to the physicians of Hawaii. Through the medical profession the Journal has served the citizens of this State in an honorable, honest, and outstanding manner from its first issue continuously to the upcoming 25th anniversary edition.

As a past president of the then Hawaii Territorial Medical Association, passage of time with continuous exposure to medical affairs has provided opportunity to observe and measure the progress of many professional activities. The Hawaii Medical Journal has been in the foreground as an influence of leadership in shaping the general policies of ethics and administrative guidance.

As Editor of the Hawaii Medical Journal, you have served continuously in this capacity and have abundantly earned the congratulations and deep appreciation of all Hawaii, particularly the medical profession of our State.

Your contributions to professional writing have been outstanding and your stature among medical journal editors is deservingly in the top echelon.

My very best personal aloha.

F. J. Pinkerton, M.D., 1929-30

To the Editor:

As Editor of the Hawaii Medical Journal since its inception 25 years ago, may I extend congratulations for a job well done. Under your guidance, I feel sure this publication will continue to increase its prestige among similar publications of our sister states.

Joseph E. Strode, M.D., 1931-32

To the Editor:

Not only the medical profession of Hawaii, but the entire Hawaiian community, is to be congratulated on the occasion of the 25th anniversary of the establishment of the Hawaii Medical Journal—an outstanding professional publication which has consistently recorded and disseminated the story of medicine's progress in Hawaii since 1941. And members of the profession should, on this occasion, extend their deep and sincere appreciation to you, Dr. Harry L. Arnold Jr., who rate as founder of the Journal and its untiring editor during the entire quarter century of its existence.

Lyle G. Phillips, M.D., 1936-37

To the Editor:

I am envious, Harry, that you have completed twenty-five years as Editor of the Hawaii Medical Journal. I was the first elected editor of the Journal and but for Pearl Harbor, I might be the one completing twenty-five years of wonderful service to the Journal, the Association, and to my community. I doubt that I could have continued for such a long period for I don't believe I could have found the time demanded by this job. It must have been a labor of love for you because I think you have worn well. The Journal has improved with the years. I have only praise for the Editor and wish him well on his next twenty-five. Congratulations!

Douglas B. Bell, M.D., 1943-44

To the Editor:

It is always a pleasure to read your Journal. I am very, very happy to know that this is the month of the quarter-century anniversary of your being editor.

You certainly have done a superb job.

Robert B. Faus, M.D., 1947-48

To the Editor:

It gives me a great deal of pleasure to offer my congratulations on the 25th anniversary of the Hawaii

Medical Journal and I would like to express my appreciation of the quiet, cultured, and efficient manner in which you have conducted the editorial policy of this periodical.

H. E. Crawford, M.D., 1949-50

To the Editor:

I am proud to participate in the 25th anniversary of the Hawaii Medical Journal. As editor over this period, you have made a major contribution to medical communication throughout the State. You have developed the format and literary material to a high degree of perfection. In comparison with other state medical journals, it will rank near the top.

I have served with you on many committees and meetings and have always found you to be a most devoted and delicated disciple of Aesculapius.

Rogers Lee Hill, M.D., 1950-51

To the Editor:

I wish to extend my congratulations to the Hawaii Medical Journal and to its Editor, Harry L. Arnold, Jr,. M.D., on the silver anniversary of the Journal.

From a mimeographed report of the transactions of the Medical Association to a first-class scientific journal with stature and prestige in the world of medicine is the story in brief of the Hawaii Medical Journal over the past 25 years.

The success of the Journal is due to the untiring efforts and the superior leadership of its Editor. You have given us a fine medical journal in which medical progress can be documented in a superb manner. An article published in the Hawaii Medical Journal receives prompt national and international recognition.

To you and the Hawaii Medical Journal I extend my fondest aloha and thanks.

Edwin K. Chung-Hoon, M.D., 1953-54

To the Editor:

I have watched the growth of the Hawaii Medical Journal from its beginning. No finer publication of its kind exists. It fills a much needed want in Hawaii's medical field.

Like all publications of this type, it is only as good as its editor. Your genius and untiring efforts shine with reflected brilliance from each page and issue. I feel honored in rendering this tribute.

Clarence E. Fronk, M.D., 1955-56

To the Editor:

It is a distinct pleasure to have this opportunity to acknowledge the many hours that our Editor has devoted toward making the Hawaii Medical Journal the fine publication it is. Of special interest are the editorials—always lively and well written.

It is my hope, as I am sure it is of every member of the Association, that you will find time to continue your editorship for many more years.

Webster Boyden, M.D., 1956-57

To the Editor:

I would like to take this opportunity to congratulate the Hawaii Medical Journal on this twenty-fifth anniversary. It is also my privilege and pleasure to personally express appreciation to you, its editor, for your steadfast devotion to the medical profession through continuous leadership throughout all these years.

The work has not been without difficulties and your outstanding contribution to the development of medicine in Hawai.i has been unparalleled.

Samuel L. Yee, M.D., 1957-58

To the Editor:

May I, as past president of the Hawaii Medical Association, congratulate you as Editor of the Hawaii Medical Journal on your Silver Jubilee. I receive several state bulletins and must say that none of them compares in format or content with our State Journal.

In all honesty I must admit that I wasn't able to get much out of your articles written in Interlingua but they did lend an interest to the publication and there are individuals who found them useful.

My compliments and kindest regards to your father, Harry Sr., and with best wishes for a successful future of the Journal, I remain

W. N. Bergin, M.D., 1958-59

To the Editor:

Hearty congratulations on the 25th Anniversary of the Hawaii Medical Journal.

I have had the pleasure of following the progress of the Journal, since its inception, from the minor publication to its major status, and appreciate the great sacrifice you have made to accomplish it.

The medical profession is extremely fortunate to have a man of your calibre whose interest and diligent efforts have so enhanced the image of the profession in Hawaii. You are to be commended for bringing the stature of this publication to its recognized position among the medical journals of the world, and I am certain you will continue to further improve its status.

Good luck and with sincerest wishes for the future.

Toru Nishigaya, M.D., 1959-60

To the Editor:

Your twenty-five years of helpful counsel to your Association and wise leadership of the Hawaii Medical Journal provide a record of service few achieve.

It is also a record which deserves a sincere word of gratitude from those of us whom you have helped so generously all these years.

Our only compensation is that we will continue to have your steady hand of ability in the editing of the Hawaii Medical Journal.

May I join with other members in thanking you for a job well done.

Edward F. Cushnie, M.D., 1960-61

To the Editor:

You are to be congratulated for converting a bi-monthly news sheet into an outstanding scientific journal during the time you have been Editor of the Hawaii Medical Journal, a journal which is recognized throughout the West as one of the top medical journals issued in the area.

J. Alfred Burden, M.D., 1961-62

To the Editor:

I have known you for over 40 years and have always admired your ability to write and express yourself. It is hard to realize that you started the Hawaii Medical Journal 25 years ago and have been its able editor ever since. I only hope that the rest of the members of the Hawaii Medical Association realize and fully appreciate the selfless effort and time you have donated to the improvement of the medical image here in Hawaii.

My heartiest congratulations and great feeling of thank-

fulness go out to you on this 25th anniversary of the HAWAII MEDICAL JOURNAL.

RODNEY T. WEST, M.D., 1963-64

TO THE EDITOR:

The Hawaii Medical Association is most fortunate in having you as a member and Editor of our JOURNAL. You are endowed with a unique combination of medical knowledge, broad intellectual interests, a facile wit, and a superior ability to communicate both verbally and in writing. We admire not only these attributes but your dedication and perserverence in the continued production by a small state of a superior medical journal.

May your years be long and your courage equal to continue doing this excellent work.

SAMUEL D. ALLISON, M.D., 1964-65

TO THE EDITOR:

During the past quarter of a century the HAWAII MEDICAL JOURNAL has long since taken its place among the fine state medical journals of the United States. This has been due to your arduous labor and diligent attention to detail. You have served not only in the capacity of editor, but as grammarian, historian, and student of religion. You have done an outstanding job without benefit, I am sure, of anyone's having said "thank you for a job well done." I doubt that any lack of grateful expression has bothered you, for I am sure you know that one's labors are not always rewarded and that "he who sows does not always reap." The reward you have had has been one of a feeling of personal accomplishment and of performing a service for your colleagues and the community in which we live. After all is said and done this is all that truly counts. It lives on beyond our life's span. Not having ever formally expressed my appreciation to you for your work of devotion, I do so at this time.

Aloha to a fine Editor!

O. D. PINKERTON, M.D., 1965-66

---

# Aloha United Fund Drive FACTS




*Campaign:* September 22 through November 1, 1966.

*Goal:* $2,899,130.

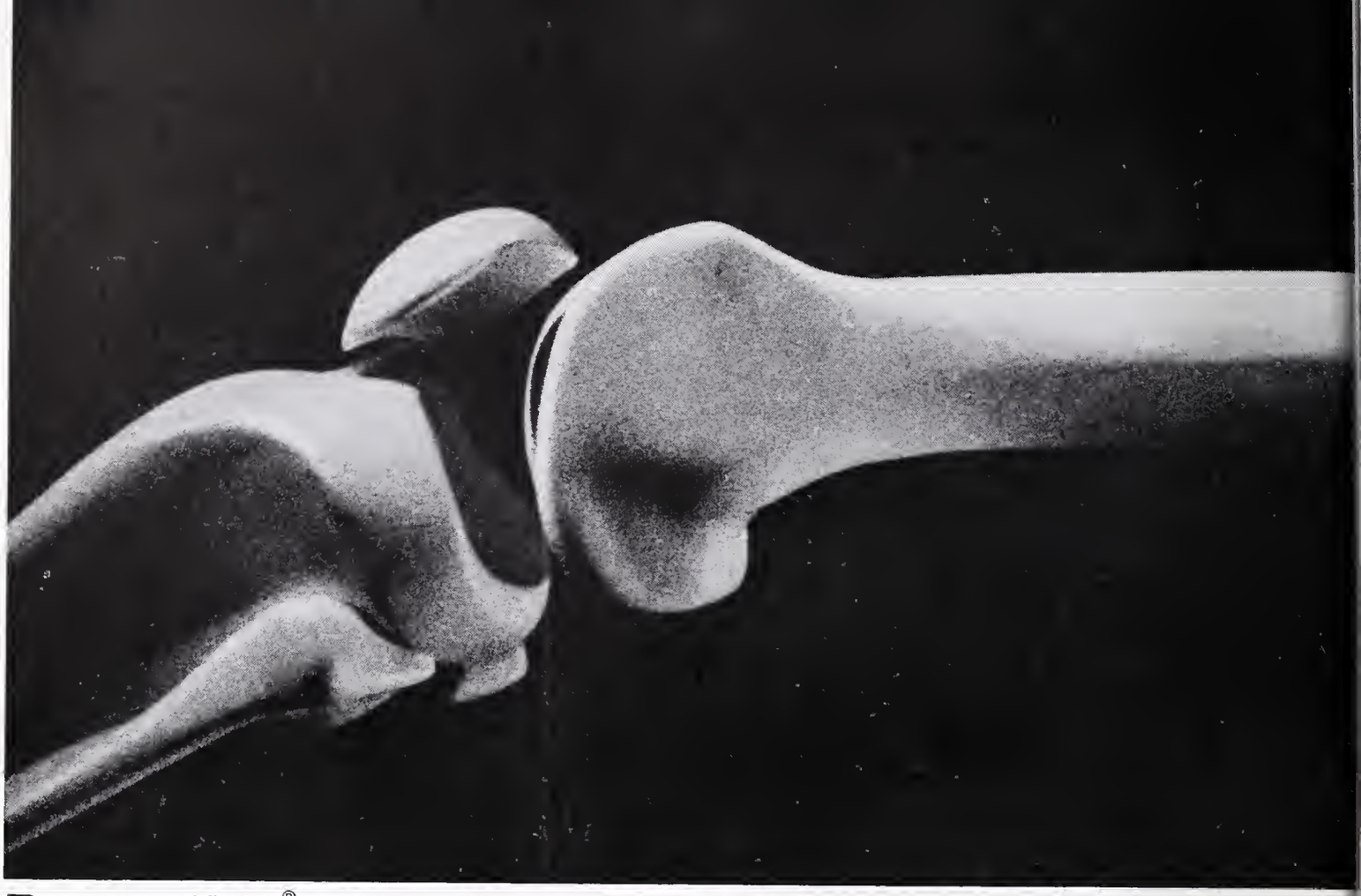
*Concentration:* The campaign is confined to the business, industrial, labor and government communities on Oahu (the City and County of Honolulu).

*People:* The campaign will be conducted by 8,000 volunteers who will contact 270,000 people and 1,100 business, labor, industrial and government organizations.

*Donations:* Use of the "Fair Share" scale of giving through payroll deduction will be stressed.

For physicians earning from $10,000 to $20,000 annually, the suggested scale is graduated upward from 1% to 2% of the net annual earnings.

*Purpose:* The campaign is to raise funds during a single annual drive to help support the 1967 operating budgets of 42 separate health, welfare, and recreational organizations with chapters on Oahu.



# Butazolidin® alka

phenylbutazone, 100 mg.
dried aluminum hydroxide gel, 100 mg.
magnesium trisilicate, 150 mg.
homatropine methylbromide, 1.25 mg.

# Usually works within 3 to 4 days in osteoarthritis

The trial period need not exceed 1 week. In contrast, the recommended trial period for indomethacin is *at least 1 month.*

That's why it's logical to start therapy with Butazolidin alka—you'll know quickly whether or not it works. And usually, it will.

A large number of investigators have reported major improvement in about 75% of cases. Some patients have gone into remission. Relief of stiffness and pain may be followed quickly by improved function and resolution of other signs of inflammation. And Butazolidin alka is well tolerated, especially since it contains antacids and an antispasmodic to minimize gastric upset.

**Contraindications**
Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. Because of the increased possibility of toxic reactions, the drug should be used with greater care in the elderly and should not be given when the patient is senile or when other potent chemotherapeutic agents are given concurrently. Large doses of Butazolidin alka are contraindicated in patients with glaucoma.

**Warning**
If coumarin-type anticoagulants are given simultaneously, the physician should watch for excessive increase in prothrombin time.

Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Patients receiving such concomitant therapy should be carefully observed for this effect.

Use with caution in the first trimester of pregnancy.

**Precautions**
Before prescribing, the physician should obtain a detailed history and perform a complete physical and laboratory examination, including a blood count. The patient should be kept under close supervision and should be warned to report immediately fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools. Regular blood counts should be made to guard against blood dyscrasias.

**Adverse Reactions**
The most common adverse reactions are nausea, edema and drug rash. Moderately lowered red cell count may sometimes occur due to hemodilution. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. Infrequently, agranulocytosis, exfoliative dermatitis, Stevens-Johnson syndrome or a generalized allergic reaction may occur and require withdrawal of medication. Stomatitis, salivary gland enlargement, vertigo or languor may occur. Leukemia and leukemoid reactions have been reported but cannot definitely be attributed to the drug. Thrombocytopenic purpura and aplastic anemia are also possible side effects.

Confusional states, hyperglycemia, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hepatitis, jaundice and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently.

**Dosage**
The initial daily dosage in adults is 300-600 mg. daily in divided doses. In most instances, 400 mg. daily is sufficient. When improvement occurs, dosage should be decreased to the minimum effective level: this should not exceed 400 mg. daily, and is often achieved with only 100-200 mg. daily.

For complete details, please refer to full prescribing information.
6509-V(B)

Also available: Butazolidin®, phenylbutazone Tablets of 100 mg.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York BU-3804R

**Geigy**




# *CONGRATULATIONS*

*to those responsible*
*for 25 years of publication of the*
*Hawaii Medical Journal.*
*And especially to Dr. Arnold, Jr.*
*whose dedication, work and*
*enthusiasm has made*
*such a significant contribution*
*to the Hawaii Medical Journal*
*and to Hawaii's medical profession.*

*Mahalo.*

*MANAGER*

*SALES MANAGER*

**AMFAC INC DRUG DEPARTMENT**

# THREE TIMES A YEAR

*Your patients without a plan to economically protect them when they are in need of medical assistance may join Hawaii's own community service medical plan on an individual basis three times a year.*

*Membership is open to qualified individuals of all ages in*

MARCH — JULY — *and* — NOVEMBER

*HMSA is a non-profit, community service organization. As such it is able to provide tremendous benefits for reasonably low dues.*

*HMSA is the medical plan which gives you free choice of doctors and hospitals — an extremely desirable feature.*

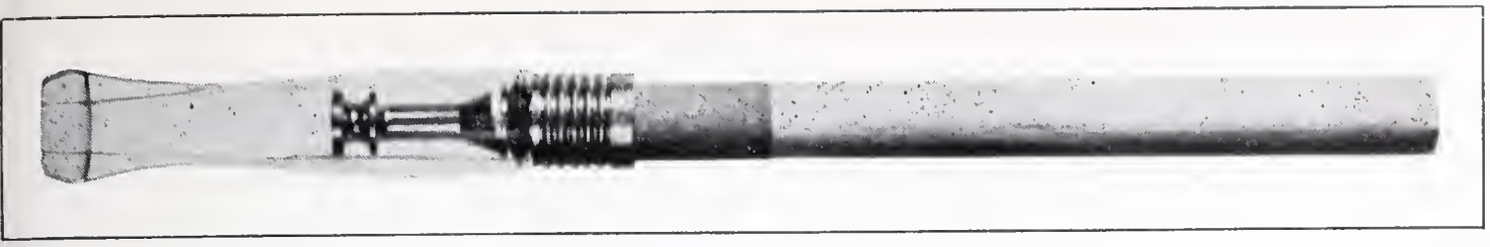
Member of Western Conference of Prepaid Medical Service Plans



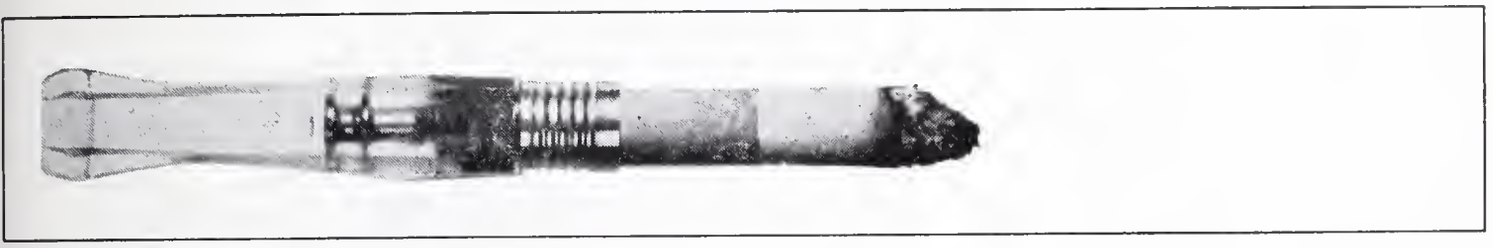

® BLUE SHIELD PLAN FOR HAWAII

## HAWAII MEDICAL SERVICE ASSOCIATION

*For More than 28 Years — Hawaii's Own / Hawaii Owned*



**Before**



**After** – tar trapped in Tar Gard after only four filter cigarettes

## Let Tar Gard help convince your patients to stop smoking send for free professional demonstration unit.

If your cigarette-smoking patient could only see some of the tar in cigarette smoke, it could convince him to stop smoking. Let Tar Gard help. A Tar Gard demonstration in your office might be the meaningful nudge he needs to make him quit. All you have to do is give one of the Tar Gard demonstration units to your patient – have him smoke four cigarettes through the unique* Tar Gard filter holder. When he sees the amount of tar trapped and realizes that normally this would stay in the mainstream of the smoke – the smoke he inhales – this could prove to be the most dramatic visual proof of the health hazards of smoking. And when your patient multiplies the amount of tar captured from four cigarettes by the related number of cigarettes he smokes over a 365 day period,** he can draw his own conclusions as to whether the smoking habit is worth the price he might have to pay.

We would like to send you a Tar Gard demonstration unit. Simply fill in the coupon (or request on your letterhead) and mail to Tar Gard, 2 Pine Street, San Francisco, California.

*Technically, Tar Gard is not a filter. It is a patented tar trapping device based on the principle of the Venturi tube, such as is employed in the bedside respirator used in critical respiratory management, the vaporizer and the aspirator. In Tar Gard, as cigarette smoke is inhaled, the pressure energy of the tar-filled smoke is accelerated (to approximately 200 mph) and then stopped abruptly by an impingement barrier, where tars are trapped.

**In an independent study carried out by Curtis and Tompkins, Ltd., Analytical Chemists, San Francisco, it was recorded that over a one year period, using 20 cigarettes per day as a base, the average amount of tar trapped in Tar Gard was 0.29 lb. (high temperature tars)

Tar Gard Company, 2 Pine St., San Francisco, Calif. 94111

Please send me Tar Gard Professional Demonstration Unit.

NAME _____

TYPE OF PRACTICE _____

ADDRESS _____

CITY _____

STATE _____ ZIP CODE _____

TAR GARD®

HMJ-2

# Norinyl® tablets

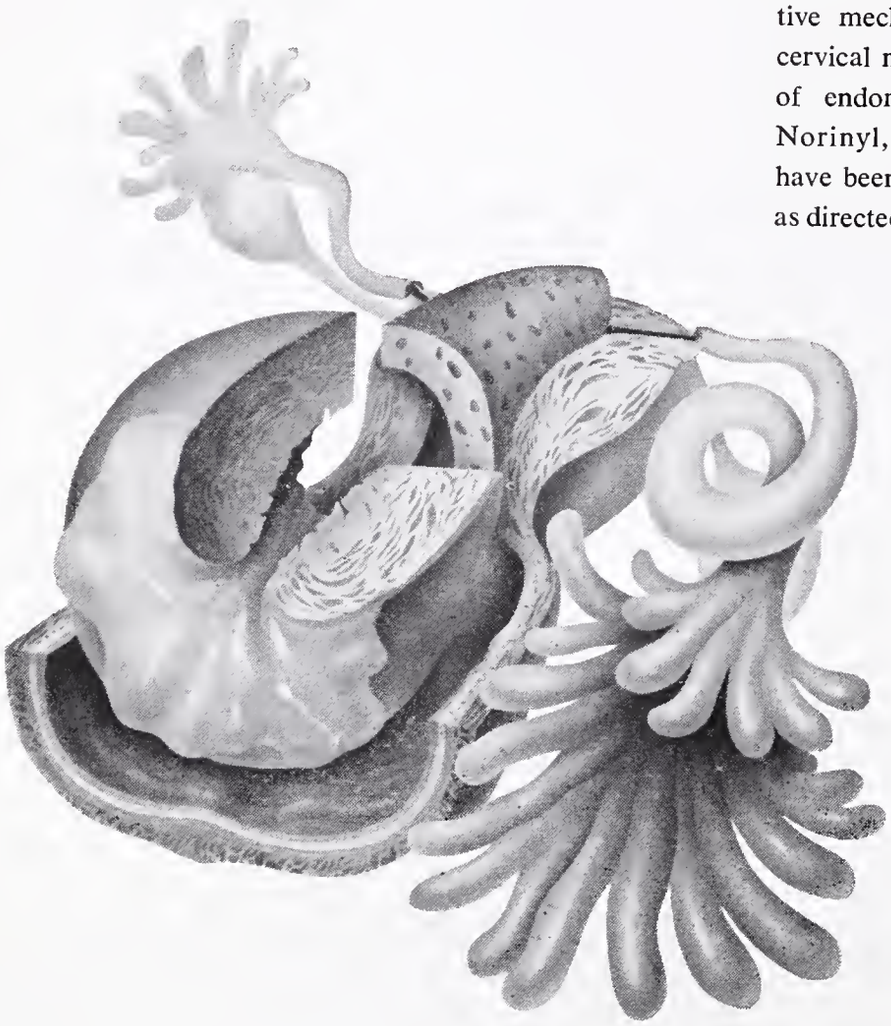
(norethindrone 2 mg. c mestranol 0.1 mg.)

# for multiple contraceptive action that has produced a record of unexcelled effectiveness

**inhibition of ovulation by means of 2 time-proved hormonal agents**

**production of a cervical mucus hostile to sperm motility and vitality**

**creation of an endometrium unreceptive to egg implantation**



**no unplanned pregnancies**

Norinyl provides multiple action for maximum assurance of success. It does not depend on ovulation inhibition alone for contraceptive effectiveness. The mechanism of action of combined hormonal therapy results in ovulation inhibition reinforced by other protective mechanisms, including a hostile cervical mucus[1-13] and an acceleration of endometrial changes.[1-3,7-16] With Norinyl, no unplanned pregnancies have been reported to date when used as directed.

# plus important supportive benefits that help her through those critical early months of oral contraception

**low incidence of side effects**

Low incidence of BTB and spotting, nausea and amenorrhea tends to minimize side effect problems and increases patient cooperation.

**no confusion about dosage**

An unbreakable "confusionproof" package makes it easy to adhere to prescribed dosage schedule: individually sealed tablets numbered from 1 through 20 *plus* monthly calendar record enables patient to double-check dosage intake by day and corresponding tablet number.




**Contraindications:** Thrombophlebitis or pulmonary embolism (current or past). Existing evidence does not support a causal relationship between use of Norinyl and development of thromboembolism. While a study which was conducted does not resolve definitively the possible etiologic relationship between progestational agents and intravascular clotting, it tends to confirm the findings of the Ad Hoc Advisory Committee appointed by the Food and Drug Administration to review this possibility. Cardiac, renal or hepatic dysfunction. Carcinoma of the breast or genital tract. Patients with a history of psychic depression should be carefully studied and the drug discontinued if depression recurs to marked degree. Patients with a history of cerebral vascular accident.

**Warning:** Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions, medication should be withdrawn.

**Precautions:** By May 1963, experience with norethindrone 2 mg.—mestranol 0.1 mg. had extended over 24 months. Through miscalculation, omission or error in taking the recommended dosage of Norinyl, pregnancy may result. If regular menses fail to appear and treatment schedule has not been adhered to, or if patient misses two menstrual periods, possibility of pregnancy should be resolved before resuming Norinyl. If pregnancy is established, Norinyl should be discontinued during period of gestation since virilization of the female fetus has been reported with oral use of progestational agents or estrogen. When lactation is desired, withhold Norinyl until nursing needs are established. Existing uterine fibroids may increase in size. In metabolic or endocrine disorders, careful clinical preevaluation is indicated. A few patients without evidence of hyperthyroidism had elevated serum protein-bound iodine levels, which in the light of present knowledge, does not necessarily imply hyperthyroidism. Protein-bound iodine increased following estrogen administration. Bromsulphalein retention has occurred in up to 25% of patients without evidence of hepatic dysfunction. Studies from 24-hour urine collections have shown an increase in aldosterone and 17-ketosteroids and decrease in 17-hydroxycorticoid levels. Thus, Norinyl should be discontinued prior to and during thyroid, liver or adrenal function tests. Because progestational agents may cause fluid retention, conditions such as epilepsy, migraine and asthma require careful observation. Thus far no deleterious effect on pituitary, ovarian or adrenal function has been noted; however, long-range possible effect on these and other organs must await more prolonged observation. Norinyl should be used with caution in patients with bone, renal or any disease involving calcium or phosphorus metabolism.

**Side Effects:** Intermenstrual bleeding; amenorrhea; symptoms resembling early pregnancy, such as nausea, breast engorgement or enlargement, chloasma and minor degree of fluid retention (if these should occur and patient has not strictly adhered to medication plan, she should be tested for pregnancy); weight gain; subjective complaints such as headache, dizziness, nervousness, irritability; in a few patients libido was increased. In a total of 3,090 patients, 2.2% discontinued medication because of nausea.

NOTE: See sections on contraindications and precautions for possible side effects on other organ systems.

**Dosage and Administration:** One Norinyl tablet orally for 20 days, commencing on day 5 through and including day 24 of the menstrual cycle. (Day 1 is the first day of menstrual bleeding.)

**Availability:** Dispensers of 20 and 60 tablets; bottles of 100.

**References:** 1. Council on Drugs. JAMA 187 664 (Feb. 29) 1964 2. Bryans, F. E.: Canad Med Ass J 92:287 (Feb. 6) 1965. 3. Goldzieher, J. W . Med Clin N Amer 48:529 (Mar.) 1964 4. Cohen, M. R.: Paper presented at Symposium on Low-Dosage Oral Contraception, Palo Alto, Calif , July 15, 1965. Reported in Med Sci 16:26 (Nov ) 1965. 5. Hammond, D. O.: Ibid. 6. Rice-Wray, E., Goldzieher, J. W., and Aranda-Rosell, A · Fertil Steril 14:402 (Jul.-Aug ) 1963. 7. Goldzieher, J W , Moses, L. E., and Ellis, L. T.: JAMA 180:359 (May 5) 1962. 8. Kempers, R. D.: GP 29:88 (Jan.) 1964 9. Tyler, E. T.: JAMA 187:562 (Feb. 22) 1964. 10 Rudel, H. W., Martinez-Manautou, J., and Maqueo-Topete, M · Fertil Steril 16:158 (Mar. - Apr ) 1965. 11. Flowers, C. E., Jr · N Carolina Med J 25:139 (Apr.) 1964. 12. Goldzieher, J. W : Appl Ther 6:5D3 (June) 1964. 13. The Control of Fertility. Report adopted by the Committee on Human Reproduction of the American Medical Association. JAMA 194.462 (Oct. 25) 1965. 14. Flowers, C. E., Jr.: JAMA 188:1115 (June 29) 1964. 15. Merritt, R. I.: Appl Ther 6:427 (May) 1964. 16. Newland, D. O.: Paper presented at Symposium on Low-Dosage Oral Contraception, Palo Alto, Calif., July 15, 1965. Reported in Med Sci 16:26 (Nov.) 1965.

norethindrone—an original steroid from

SYNTEX

LABORATORIES INC. PALO ALTO, CALIF

# Norinyl® tablets

(norethindrone 2 mg. ē mestranol 0.1 mg.)

**for multiple contraceptive action**



*Now, now, Mrs. Forsythe, we've never lost a cold patient yet.*

When she's experiencing acute discomfort from cold symptoms, it's small wonder the patient becomes distressed about her condition.

She will breathe easier when you prescribe Novahistine LP.

Novahistine LP is a long-acting decongestant that helps restore normal mucus secretion and ciliary activity—physiologic mechanisms which prevent infection of the respiratory tract. A dose of two tablets taken in the morning and repeated in the evening will usually keep air passages clear for 24 hours.

Use cautiously in individuals with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution patients who operate machinery or motor vehicles that drowsiness may result.

Each Novahistine LP tablet contains: phenylephrine hydrochloride, 25 mg., and chlorpheniramine maleate, 4 mg.

DOW **PITMAN-MOORE** Division of The Dow Chemical Company, Indianapolis

# NOVAHISTINE® LP

*For relief of nasal congestion.*



Saxon

# BASIC BACTERICIDAL ANTIBIOTIC THERAPY IN INFECTIONS THROUGHOUT THE BODY







# THE PENICILLIN YOU USE LIKE A BROAD-SPECTRUM ANTIBIOTIC

Instead of the older, essentially bacteriostatic broad-spectrum agents, you can now treat bacterial infections with the first broad-spectrum penicillin — bactericidal, well-tolerated Polycillin (ampicillin trihydrate).

**Basic in respiratory infections**
Because Polycillin (ampicillin trihydrate) is so effective against *D. pneumoniae*, streptococci, and sensitive staphylococci, and because it is unsurpassed against *H. influenzae*, it can be considered as basic therapy in respiratory infections.

**An innovation in genitourinary infections**
Polycillin (ampicillin trihydrate) is effective where usual doses of penicillin were rarely effective before—throughout the urinary tract. It was the most effective drug tested against *E. coli*,[1] *P. mirabilis*,[1] and enterococci.[2]

**A new approach to meningitis**
In bacterial meningitis, Polycillin-N (sodium ampicillin) for Injection has proved to be so effective and simple to use that it has been recommended as the "drug of choice"[3] for initial therapy.

**Terminates infection rapidly and with remarkable safety**
Broad-spectrum ampicillin—instituted early, even pending laboratory reports—can enhance the likelihood of terminating infection rapidly, minimizing the chance of recurrence while posing virtually no hazard of toxicity.

**Available forms and strengths allow broad applications**
Prescribe the unit dosage and route of administration best suited for the severity of infection and duration of therapy.

Polycillin (ampicillin trihydrate) Capsules—250 mg., bottles of 24 and 100; 500 mg., bottles of 16 and 100.

For Oral Suspension—125 mg./5 ml., bottles of 60 ml., 80 ml. and 150 ml.; 250 mg./5 ml., bottles of 80 ml.

Polycillin-N (sodium ampicillin) for I.M./I.V. injection, vials of 250 and 500 mg.

*References:* 1. Anderson, K.N., *et al.*: JAMA *187*:555 (Feb. 22) 1964.
2. Petersdorf, R.G., and Sherris, J.C.: Am. J. Med. 39:766 (Nov.) 1965.
3. Mathies, A.W., Jr., *et al.*: Synopsis of experience with ampicillin in bacterial meningitis. Presented at 4th Internat. Cong. Chemother., Washington, D.C., Oct. 18-21, 1965.

BRISTOL THERAPEUTIC SUMMARY: For complete information, consult Official Package Circular.

*Indications:* Infections due to susceptible strains of Gram-negative bacteria (including Shigellae, *S. typhosa* and other Salmonellae, *E. coli, H. influenzae, P. mirabilis, N. gonorrhoeae* and *N. meningitidis*) and Gram-positive bacteria (including streptococci, pneumococci and nonpenicillinase-producing staphylococci).

*Contraindications:* A history of serious allergic reactions to penicillin and infections due to penicillinase-producing organisms.

*Precautions:* Typical penicillin-allergic reactions may occur, especially in hypersensitive patients. Mycotic or bacterial superinfection may occur. Experience in newborn and premature infants is limited and caution should be used in treatment, with frequent organ function evaluations. Safety for use in pregnancy is not established. In gonorrheal therapy, serologic tests for syphilis should be performed initially and monthly for 3 months. Assess renal, hepatic and hematopoietic function intermittently during long-term therapy.

*Adverse Reactions:* Skin rash, pruritus, urticaria, nausea, vomiting, diarrhea and anaphylactic reactions. Mild transient elevations of SGOT or SGPT have been noted.

*Usual Dosage:* Adults—250 or 500 mg. *q.* 6 *h.* (according to infection site and offending organisms). Children—50-100 mg./Kg./day in 3 to 4 divided doses (depending on infection site and offending organisms). Children weighing more than 20 Kg. should be given an adult dose. Beta-hemolytic streptococcal infections should be treated for at least 10 days.

BRISTOL
BRISTOL LABORATORIES
Division of Bristol-Myers Co.
Syracuse, New York

A dosage form for every patient

**Polycillin®**
(ampicillin trihydrate)
CAPSULES

**Polycillin®**
(ampicillin trihydrate)
FOR ORAL SUSPENSION

**Polycillin-N™**
FOR INJECTION – I.M./I.V.

# MOLECULAR REMODELING—

## *laboratory exercise or clinical necessity?*

More than twenty-five years have passed since the discovery of the diuretic activity of sulfanilamide started pharmacologists on a succession of molecular remodelings to find the ideal diuretic.

### Diuresis—a sought-after clinical effect from an unwanted side effect

It started in 1937 when a clinician reported that the administration of a sulfonamide was sometimes accompanied by an unexplainable side effect—metabolic acidosis.[1] Three years later the side effect was explained. The sulfonamide radical of sulfanilamide inhibited carbonic anhydrase,[2] the enzyme responsible for converting carbon dioxide and water to hydrogen ions and bicarbonate ions.

Later, other investigators showed by dog experiments that metabolic acidosis probably resulted when the inhibition of carbonic anhydrase upset the exchange of hydrogen and sodium ions, causing increased excretion of sodium as the bicarbonate.[3]

It was twelve long years after the first report of the unexplainable side effect (metabolic acidosis) that it was finally shown that large doses of sulfanilamide administered to edematous patients were indeed capable of promoting diuresis.[4] However, the possibility of toxic effects from its prolonged use and its relatively weak diuretic action made it impractical for clinical use as a diuretic.[5]

Because the inhibition of carbonic anhydrase seemed to be the key to effective diuresis, investigators began to look for more potent enzyme inhibitors —in the hopes that they would be more effective diuretics.

The most important of these early compounds, acetazolamide, enjoyed several years of fairly wide clinical use.

Its carbonic anhydrase inhibitory activity was several hundred times greater than that of sulfanilamide.[6] The increase in inhibitory activity, however, increased not only the excretion of sodium and bicarbonate ions, but also the excretion of potassium.[7] And, like its predecessor, acetazolamide precipitated mild acidosis. Its prolonged use could result in hypokalemic acidosis.[7]

### The 'thiazides'—an answer to the metabolic acidosis caused by carbonic anhydrase inhibition

Despite the fact that the sulfonamide group appeared to be responsible for carbonic anhydrase inhibition which in turn appeared to be responsible for diuresis, investigators began to synthesize compounds with structural alterations to the sulfonamide group.

The first major breakthrough came with the synthesis of chlorothiazide. Altering the sulfonamide group did indeed alter the ability of chlorothiazide to inhibit carbonic anhydrase—it was only 1/10th as potent as acetazolamide in inhibiting the enzyme.[8] Despite the drop in inhibitory potency, however, chlorothiazide proved to be an effective diuretic—an observation that led to the conclusion that its diuretic action was due to some mechanism other than its action on carbonic anhydrase.[9,10]

For effective diuresis, chlorothiazide was administered in daily dosages ranging from 250 to 2000 mg.[11] It increased the excretion of sodium and chloride; and, to a lesser extent, potassium and bicarbonate.[11] The excretion of potassium appeared to be maximal at higher dose levels at which, theoretically, the carbonic anhydrase inhibitory effect is more active.[11] Its prolonged use, therefore, could sometimes result in metabolic hypokalemic, hypochloremic alkalosis.[7]

### Naturetin—effective diuresis with more favorable electrolyte balance

Other thiazides followed—with improvements being aimed at two particular areas: 1. attempts to increase diuretic action in relation to the milligram potency of the drug, and 2. attempts at a more favorable sodium/potassium ratio in the urine, i.e., to decrease the excretion of potassium while maintaining the excretion of sodium.[12]

One of these, Naturetin, Squibb Bendroflumethiazide, has made advances on both these points. "By adding a 3-benzyl radical to hydroflumethiazide a rather dramatic reduction in dose range is accomplished. With this drug, effective sodium excretion is obtained with doses between 2.5 and 10 mg., which is a 200 to 1 ratio as compared to chlorothiazide..."[13]

Moreover, due probably to its virtual lack of carbonic anhydrase inhibition, Naturetin (bendroflumethiazide) has been shown to cause less potassium and bicarbonate loss and less alteration in urinary pH than either chlorothiazide or hydrochlorothiazide.

Naturetin is outstandingly effective not only in establishing, but also in maintaining, excretion of retained fluid in edematous patients. And its duration of action is sufficiently prolonged to allow a single daily administration in most patients. Naturetin is also an effective antihypertensive agent.

**Contraindications:** Severe renal impairment; previous hypersensitivity.

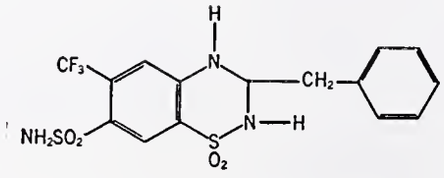
**Warning:** Ulcerative small bowel lesions have occurred with potassium-containing thiazide preparations or with enteric-coated potassium salts supplementally. Stop medication if abdominal pain, distension, nausea, vomiting, or G.I. bleeding occur.

**Precautions:** The dosage of ganglionic blocking agents, veratrum, or hydralazine when used concomitantly must be reduced by at least 50% to avoid orthostatic hypotension. Electrolyte disturbances are possible in cirrhotic or digitalized patients.

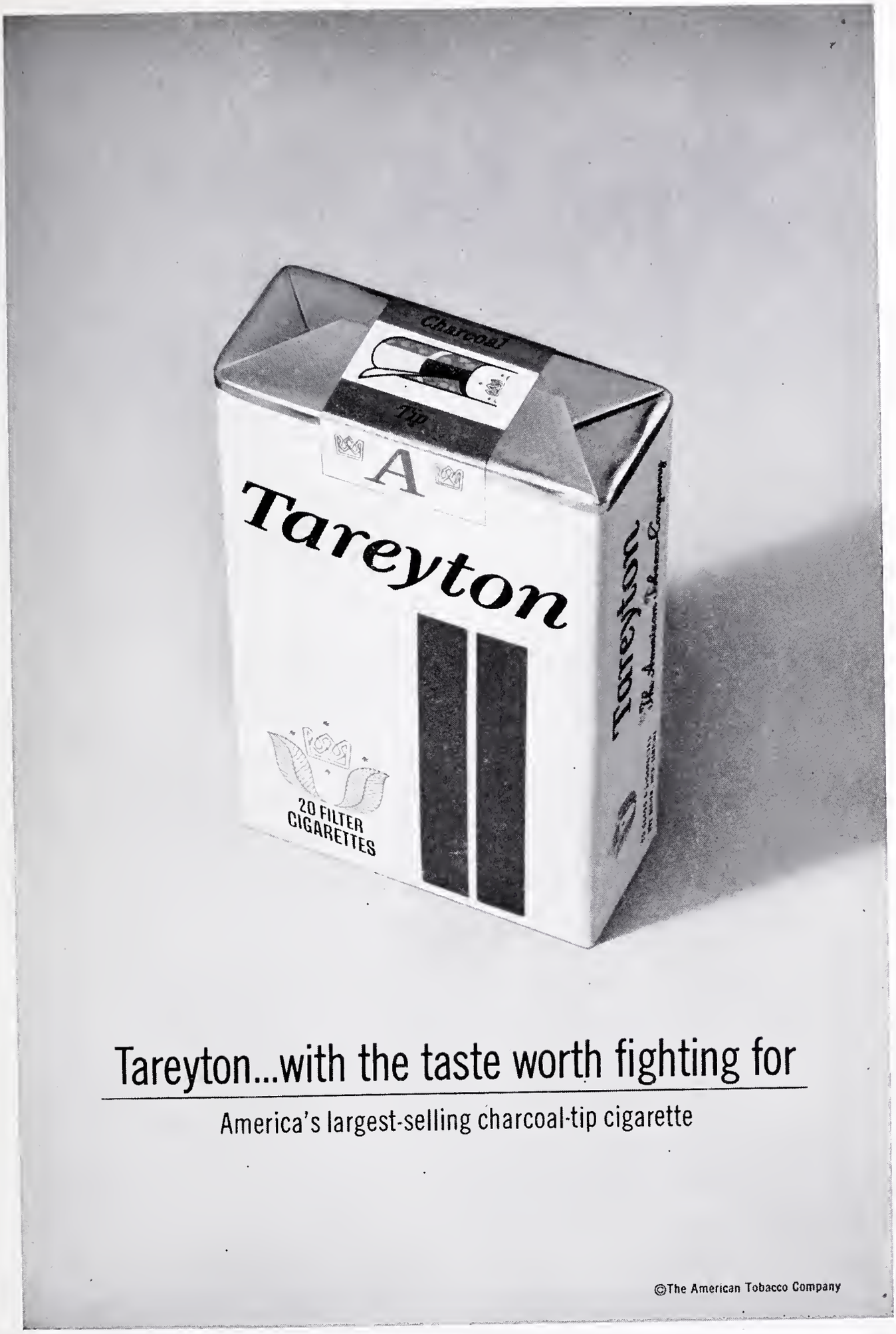
**Side Effects:** Bendroflumethiazide may cause increases in serum uric acid, unmask diabetes, increase glycemia and glycosuria in diabetic patients and may cause hypochloremic alkalosis, hypokalemia; cramps, pruritus, paresthesias, and rashes may occur.

**Supplied:** Naturetin (Squibb Bendroflumethiazide) 5 mg. and 2.5 mg. tablets. Also available Naturetin c K [Squibb Bendroflumethiazide (5 or 2.5 mg.) with Potassium Chloride (500 mg.)]. For full information, see Product Brief.

**References: 1.** Southworth, H.: Proc. Soc. Exper. Biol. & Med. *36*:58, 1937. **2.** Mann, T. and Keilin, D.: Nature *146*:164, 1940. **3.** Pitts, R. F., and Alexander, R. S.: Am. J. Physiol. *144*:239, 1945. **4.** Schwartz, W. B.: New England J. Med. *240*:173, 1949. **5.** Friedberg, C. K., in Moyer, J. H., and Fuchs, M.: Edema Mechanisms and Management, Philadelphia, W. B. Saunders Co., 1960, p. 259. **6.** Cumming, J. R.; Tabachnick, E., and Seelig, M., in Moyer, J. H., and Fuchs, M.: op. cit., p. 254. **7.** Werko, L., in Moyer, J. H., and Fuchs, M.: op. cit., p. 188. **8.** Beyer, K. H., Jr., in Moyer, J. H., and Fuchs, M.: op. cit., p. 274. **9.** Maren, T. H., and Wiley, C. E.: J. Pharmacol. & Exper. Therap. *143*:230, 1964. **10.** Earley, L. E., and Orloff, J.: Ann. Rev. Med. *15*:149, 1964. **11.** Fuchs, M., and Mallin, S. R., in Moyer, J. H., and Fuchs, M.: op. cit., p. 276. **12.** Ford, R. V., in Moyer, J. H., and Fuchs, M.: op. cit., p. 290. **13.** cited in Fuchs, M., and Mallin, S. R. (ref. 11): op. cit., p. 283.




Naturetin®
SQUIBB BENDROFLUMETHIAZIDE
to reduce excess fluid
or high blood pressure


Charcoal
Tip
A
Tareyton
20 FILTER CIGARETTES
Tareyton
Tareyton...with the taste worth fighting for
America's largest-selling charcoal-tip cigarette
©The American Tobacco Company



*Adaptation from Shakespeare Rare Print Collection*

*"Give me a bowl of wine*
*—in this I bury*
*all unkindness"*

—SHAKESPEARE



**DEAR DOCTOR:**

Will Shakespeare was a pretty fair hostler and real estate investor, a pal of Francis Drake and Walter Raleigh, much admired by Queen Elizabeth, and a tophole poet and playwright —but no physician.

Nevertheless, he had a rather good idea of the helpfulness of wine in cases of stress, as you can see above.

Like Will, we wish to recommend a daily bit of wine, with your meals for your own personal stress, Doctor, in your rugged profession.

Also, for your wife's stress at home, we'd like to prescribe a 24-page folder, "WINE COOKERY THE EASY WAY," which will help her to relax in the kitchen (and help you at the barbecue). We'll mail it to you (free) if you'll just drop us a note on your professional letterhead.

By the way, we'll also send you our newly revised 64-page booklet, "USES OF WINE IN MEDICAL PRACTICE," which summarizes a quarter century of scientific research, in America and Europe, as an aid to your profession.

We hope you will request one or both of these free booklets.

As you know, wine stimulates gastric flow; can help the convalescing patient; the patient lacking appetite; can help relieve anxiety; can help patients suffering from the malabsorption syndrome—and helps hospital and geriatric home morale. Shakespeare had a good idea there. And many physicians and hospital administrators are also sharing that idea.

Here's a toast in California wine, Doctor—to your health!

*The Winemakers of California*

WINE ADVISORY BOARD, 717 MARKET ST., DEPT 1, SAN FRANCISCO, CALIF. 94103

# when anxiety is part of the clinical picture

# Librium®
## (chlordiazepoxide HCl)

Before prescribing, please consult complete product information, a summary of which follows:

**Contraindications:** Patients with known hypersensitivity to the drug.

**Warnings:** Caution patients about possible combined effects with alcohol and other CNS depressants. Warn against hazardous occupations requiring complete mental alertness. Use caution in administering to addiction-prone patients or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

**Precautions:** In elderly and debilitated and in children over five, limit dosage to smallest effective amount, increasing gradually as needed and tolerated. In general, concomitant use with other psychotropics is not recommended. Paradoxical reactions have been reported in psychiatric patients and hyperactive aggressive children. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically. Observe usual precautions in presence of impaired renal or hepatic function, impending depression and suicidal tendencies.

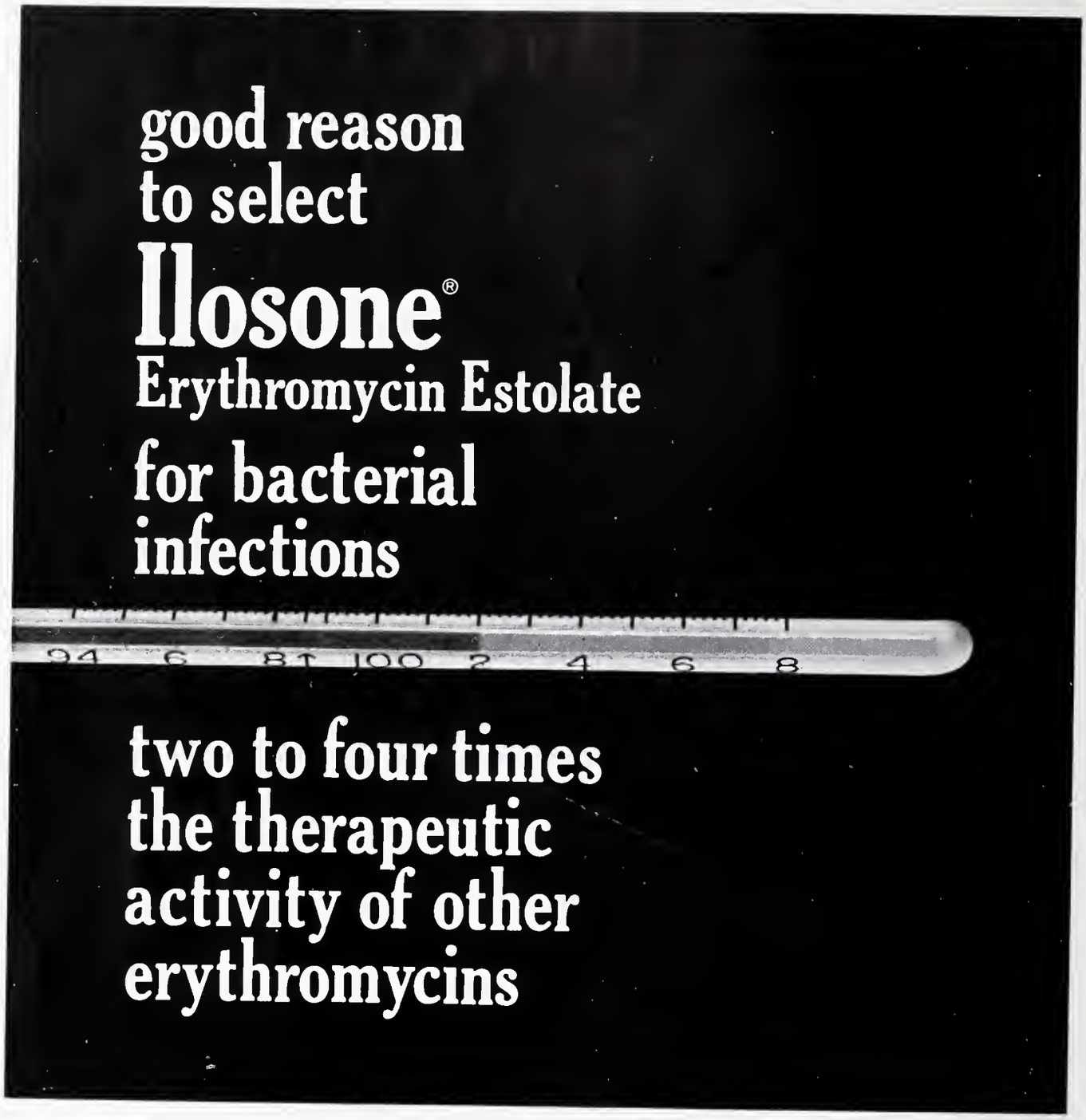
**Adverse reactions:** Drowsiness, ataxia and confusion may occur, especially in elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. Syncope occurs rarely. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis, jaundice and hepatic dysfunction) may develop occasionally, making periodic blood counts and liver-function tests advisable during protracted therapy. Individual maintenance dosages should be determined.

**Dosage:** *Oral*—Adults: Mild to moderate anxiety and tension, 5 or 10 mg t.i.d. or q.i.d.; severe states, 20 or 25 mg t.i.d. or q.i.d. Geriatric patients: 5 mg b.i.d. to q.i.d.

**Supplied:** Capsules, 5 mg, 10 mg and 25 mg—bottles of 50.

ROCHE

**Roche Laboratories** • Division of Hoffmann-La Roche Inc • Nutley, N.J. 07110




CONTRAINDICATIONS: Ilosone is contraindicated in patients with a known history of sensitivity to this drug and in those with preexisting liver disease or dysfunction.

SIDE-EFFECTS: Even though Ilosone is the most active oral form of erythromycin, the incidence of side-effects is low. Infrequent cases of drug idiosyncrasy, manifested by a form of intrahepatic cholestatic jaundice, have been reported. There have been no known fatal or definite residual effects. Gastro-intestinal disturbances not associated with hepatic effects are observed in a small proportion of patients as a result of a local stimulating action of Ilosone on the alimentary tract. Although allergic manifestations are uncommon with the use of erythromycin, there have been occasional reports of urticaria, skin eruptions, and, on rare occasions, anaphylaxis.

DOSAGE: *Children under 25 pounds*—5 mg. per pound of body weight every six hours. *Children 25 to 50 pounds*—125 mg. every six hours. *Adults and children over 50 pounds*—250 mg. every six hours. For severe infections, these dosages may be doubled.

Available in Pulvules®, suspension, drops, and chewable tablets. Ilosone Chewable tablets should be chewed or crushed and swallowed with water.

*Additional information available to physicians upon request.*
*Eli Lilly and Company, Indianapolis, Indiana 46206.*

Lilly

600541

*Our Medical Journal is celebrating its silver anniversary.*

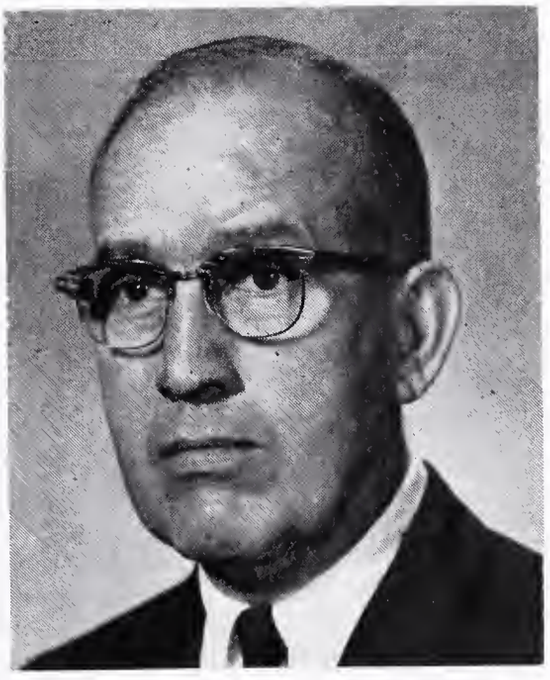
*Its 25 years of continuous excellence was made possible by one man. He is Dr. Harry L. Arnold, Jr., whose devotion to medicine and to this organization over a quarter-century has been noted internationally.*

*His scientific contributions are numerous and outstanding. His visionary efforts for a quarter-century have contributed to the world prestige of the* JOURNAL *and to the prestige of organized medicine in Hawaii.*

*I take pride in offering the deepest gratitude of the Hawaii Medical Association to Dr. Harry L. Arnold, Jr., who has served so long and so well without remuneration. The* HAWAII MEDICAL JOURNAL *belongs to him alone.*

THEODORE T. TOMITA, M.D.
*President, Hawaii Medical Association*





# Tribute to Harry Loren Arnold, Jr., on the 25th Anniversary of the H.M.J.--1941-1966

HUGH LYTLE, *Honolulu*

"THE BULLETIN is dead, long live the Journal," said the lead editorial in the first issue of the HAWAII MEDICAL JOURNAL which appeared in September, 1941. The first issue was a neatly printed, slick paper production of 74 pages that replaced the mimeographed "Bulletin" that had been circulated among medical practitioners of Hawaii since 1938. When the cost of mimeographing soared, someone asked: "Why not print a full-fledged Journal?" "Why not, indeed," was the answer. And the Annual Meeting of 1941 gave the JOURNAL its blessing.

With the current issue, the HAWAII MEDICAL JOURNAL observes its 25th anniversary. The quarter-century of service is commemorated by the silver sheen of the cover, which temporarily replaces the canary yellow that usually identifies the publication. During this entire period, the JOURNAL has been guided by one editor and one alone. He is Dr. Harry L. Arnold, Jr., whose only salary has been the rewards that come to those who serve their fellow men without thought of material gain.

The late Dr. Alfred L. Craig was President of

the then Hawaii Territorial Medical Association when the JOURNAL sprang into existence almost coincidentally with the opening of the new Mabel Smyth Memorial Building on the grounds of The Queen's Hospital. Dr. R. O. Brown was Secretary and Dr. Douglas Bell was Treasurer. The Association was comprised of 273 members, of whom 197 were practicing on Oahu. Hawaii had 35; Maui, 21; and Kauai, 20.

Penicillin wasn't yet on the market. The sulfonamides were the miracle drugs, and the first issue of the JOURNAL reported a statement that "the treatment of gonorrhea by the use of sulfanilamide and its derivatives . . . is so gratifying that it almost is a pleasure to treat these cases."

Hawaii had a population of some 422,000 then, but was vibrant with a steadily intensifying drive that was called "the defense effort." Most interisland travel was carried by small steamers that rolled giddily in the rough channels. Steamer Day was still an event on the waterfront—most travel to the mainland was by sea. But the relatively new metal birds with gasoline motors were said to have an important future in store. Editors were predicting that the tourist industry might some day catch up with sugar and pineapple as an income producer and that great numbers of visitors would come to Hawaii by air.

The first issue of the JOURNAL was heavy with news of plantation health and leprosy. It contained an article by Dr. F. J. Pinkerton describing the operation of the self-imposed tonnage tax on shipping, proceeds of which were used to finance a wide range of public health activities, including plague prevention. There was a section on advances in surgery which noted that wars have repeatedly stimulated an interest in the treatment of fresh, traumatic wounds. An article on internal medicine suggested that thiamin might be of value in the treatment of toxemia of pregnancy. A suggested plantation cooperative plan was described, and the Editor had reservations concerning some of the details.

The Fifty-first Annual Meeting of the Association was reported, together with the Presidential Address of Dr. Paul Withington. The big news, however, was that medical preparedness activity in Hawaii was coming of age after beginning slowly in 1940 with the appointment of a Preparedness Committee by Dr. Gardner Black, President of the Honolulu County Medical Society. As a result there were some 80 flasks of blood plasma in storage at the City-County Emergency Hospital, "to be held to serve in case of disaster." The Blood Bank of Hawaii, founded in June, 1941, after the Public Health Committee of the Chamber of Commerce contributed $2,000, was building up its own supply and had a total of 256 units by December 7. The flasks looked impressive enough in storage, but they were not enough, as it turned out. On December 7, when Japanese planes struck Hawaii with calculated fury, Dr. F. J. Pinkerton, the Blood Bank boss, appealed for donors, who turned out at the rate of 500 a day, depositing 3,500 units of blood in the Bank's coffers in just seven days. It went out fast.

The present generation may find it difficult to realize the citizenry's preoccupation with defense matters in those days. The original Preparedness Committee appointed by Dr. Black was composed of Drs. Clarence Fronk, Joseph Palma, Fred Lam, and James Kuninobu. Those physicians laid the groundwork for an ambitious program to train units for the care of civilian casualties in the event of disaster such as war, earthquake, or fire. The committee was reorganized and expanded, and with Dr. Robert Faus as Executive Officer, an intensive Territorywide schedule of training was begun. The Chamber of Commerce and the Red Cross gave funds; the Armed Forces helped and advised. The City was divided into zones with first-aid stations established in each. About 3,000 lay workers were enrolled.

"On the whole," the fledgling JOURNAL reported, "the committee feels that the city is reasonably well organized for the first-aid care of casualties which might result from aerial or other hostile attacks."

Hawaii County started its own program in May, 1941, and reported success except in the matter of finding enough strong young men to act as litter bearers and to train for first-aid work. "If this indifference continues," said a report from Hilo, "some system of selective drafting may be necessary to complete the personnel; however this would not be within our province."

Maui organized a portable, central first-aid unit in the Wailuku district to be the nucleus of an islandwide program. Kauai set up a schedule of medical preparedness with Charles Fern as coordinator. Officials of county organizations were kept coming and going to confer with Dr. Faus in Honolulu and Dr. Faus made numerous interisland trips.

Such was the atmosphere when the JOURNAL made its first appearance with the promise that it would be issued on alternate months as a medium "by which the minds of our confreres may be brought into focus on problems which concern us all—problems having to do with better standards, better practice, better health regulations, better laws." "Too much thinking of the profession in the past has been done by too few," commented the young editor of the JOURNAL.

"More enlightenment, more interest, more opinions should improve the quality of our thought, and augment the effectiveness of our influence. The JOURNAL should also be a means through which the effective participation of the profession in community tasks, such as the defense programs, public health education, and communicable disease control, may be improved. In such matters, through lack of information, the efforts of doctors fully willing to put their shoulders to the wheel have not been fully utilized. . . . If to the betterment of the profession and the betterment of Hawaii, the efforts of the present and future editorial staffs are dedicated, the success of the JOURNAL is assured."

The staff didn't know it, but there would be only one more peacetime issue for several years. It appeared in November, 1941. It dealt with such matters as extrapleural thoracoplasty, the treatment of tuberculosis at Leahi, syphilis, and with mild abdominal pain due to ovulation. Editorially, the JOURNAL appraised the mental health situation in Hawaii and commented that "in the past the Territory . . . has been distinctly backward in the application of modern methods of treatment to mental disease." The Editor called for "an institution apart from the Territorial Hospital for the study and classification and observation of mental disorders not yet known to be psychoses."

War came to Hawaii on December 7, 1941, and the JOURNAL had to get special permission from the Military Government of Hawaii to tell about it. All publications in the Territory, including daily newspapers, were ordered suspended and the publishers had to have licenses before they could resume printing. This was a mere formality in most instances and regularly instituted publications didn't miss an issue.

The January issue of the JOURNAL was delayed, however, because formal authorization for publication didn't arrive until January 15. It is interesting that the author was the person who granted this permission. The first wartime issue devoted most of its space to such matters as war wounds, protection against poisonous gases, Health Department services in war emergency, blood bank procedures, and excerpts from the lectures on traumatic surgery by Dr. John J. Moorhead. It was Dr. Moorhead who was lecturing to assembled physicians in the Mabel Smyth Auditorium that Sunday morning when the call came for medical aid for victims of the Pearl Harbor attack.

Doctors, including Dr. Moorhead, departed en masse for duty at Tripler General Hospital and other assigned stations to work around the clock on war casualties.

Commenting on Dr. Moorhead's presence at that particular time, the JOURNAL editorialized: "Providence could *not* have been kinder."

The January issue, incidentally, was enlarged to 92 pages and the price raised from 35 cents for single copies to 50 cents because of its "unusual nature and size."

As the war progressed, the JOURNAL continued to expand and become broader in scope, reflecting the changing times in an isolated Territory which was becoming filled with troops and war workers living under blackout conditions which, increasingly, seemed unnecessary. Articles on blackout and health appeared, together with dissertations on night vision. The Editor was pleased to learn that when the Military Government ordered all civilians vaccinated, no less than 56 per cent of the citizenry went to their own personal physicians for shots rather than take advantage of the free immunization offered by military physicians.

The blackout was only one of the problems. Food was limited in variety and high in price. Gas and tires were rationed. So was liquor. And when people lived like moles at night they found they had to change work, entertainment, social, and eating habits. Thousands of local men, whose families had been evacuated to the mainland—out of a potential war zone—found themselves almost with the status of displaced persons.

Tensions mounted in these circumstances, and the JOURNAL was increasingly concerned with psychiatric disorders. Emotional and personality problems were discussed. The dangers of prostitution were considered at length. Commenting on a suggestion to repress prostitution, the JOURNAL editorialized: "If scattered, clandestine, wholly uncontrolled prostitution will cause less spread of venereal disease than organized and more or less controlled prostitution, then let us repress organized prostitution with a will." It was apparent, though, that the Editor had his doubts about the efficacy of enforcing virtue by padlocking the doors of Honolulu's brothels. "At all events," he concluded, "let us not merely monkey with the buzz saw. Let us either carry on with the present system or change it radically and make the change stick—and then see what happens." The system wasn't changed for several years.

Another wartime hazard considered by the JOURNAL was the increase in patronage at the numerous tattoo parlors, where from 300 to 500 men a day were decorated in color at prices ranging from $2.50 to $12.50 a design. Cases

of skin infection were being reported, and a JOURNAL article led to better sanitary conditions in the tattoo salons.

The JOURNAL wasn't a completely military manual, however. In the summer of 1943 an article suggested cigarette smoking was a factor in sterility. At about the same time, an editorial warning was given that continuous caudal anesthesia was not yet safe. But the same issue noted that "penicillin, a substance extracted from culture of the fungus, Penicillium notarium, is apparently effective against a wide variety of microorganisms."

As the years passed the JOURNAL became larger and broader in scope. Psychiatry for the general practitioner was proposed as early as 1946. The flavor and color of Hawaii was apparent when writers considered such topics as fish poisoning, the incidence of eclampsia in kona weather, the longevity of enteric pathogens in poi, the sudden death of apparently healthy young Filipino men during sleep, and the racial incidence of mental disease and stomach cancer. Hawaiian vegetables, it was stated, contained as much iron and other minerals as did those imported from California, Illinois, or Texas. "Hawaii is one of the best human laboratories in the world," said the JOURNAL in 1953.

Special issues were printed. Three such productions appeared during the very first year, dedicated to the neighbor islands of Hawaii, Maui, and Kauai with the contents produced largely by practitioners of those respective islands.

Within two years after the end of the war the story of the impact of the "Blitz" upon Hawaii's men of medicine was told in a series of personal reminiscences by physicians called to emergency duty on December 7, 1941. The series now is source material for historians.

The JOURNAL has displayed a consistently independent editorial attitude, as evidenced by its position on prostitution. It spoke early in favor of fluoridation of water and for continuance of atomic tests by the United States, which it considered necessary "as judged by today's standards and values." It was irked no end at the slow unwinding of red tape by the Office of Price Administration after the war ended. It took a dim view of the British health service—a view similar to that taken by most doctors in Britain today.

Almost 20 years ago it campaigned for relicensing of automobile drivers and for revision of laws relating to autopsies. In 1949 it reprinted an article by the late Dorothy Thompson objecting to a proposed vast extension of bureaucratic powers by passage of a compulsory health insurance law. Referring to an antitrust investigation of medical societies by the then Attorney General J. Howard McGrath, the JOURNAL said it was a case of the cookstove calling the tablecloth black.

Throughout the years the JOURNAL has evinced a keen interest in the problem of equitable distribution of the cost of medical care. And there should be no "closed shop" for doctors, the publication affirmed, in objecting to any hospital's requirement for an AMA membership as a prerequisite to staff privileges. But the Editor, who also happened to be President of the HMA in that year of 1951, pointed out that individual physicians *are* the AMA, and urged them not to let their memberships lapse.

The word "Territorial" was dropped from the name of the Association in 1951 and the JOURNAL, at the time, had editorially urged the Congress to hurry up and make Hawaii a state. During research into Association history it was found that even though the original charter, which was granted in 1856 by Alexander Liholiho, required annual meetings, some annual meetings were not recorded. After what was called the Sixty-third Annual meeting at Wailuku, Maui, in 1953, therefore, the next meeting at Honolulu became the Ninety-eighth, to conform to historical dates.

The Association celebrated its Centennial in 1956, and the big and fat March-April issue was a specially bound effort of 128 pages that contained no less than 13 historical articles, a roster of the membership, and a cumulative index as well as the program of the 100th Annual Meeting. It also contained a deserved tribute to the Woman's Auxiliary, members of which had compiled the index as one of their numerous projects. In the "This Is What's New" section it was reported that Penicillin V, unlike Penicillin G, resisted gastric digestion and could be used orally.

A new feature, "In Memoriam—Doctors of Hawaii" also appeared in the Centennial issue, recounting the lives of nine of the ten charter members of the Hawaii Medical Association. This has been a regular feature since. It was but one of many such innovations that have aroused interest in the JOURNAL. One of these, the "Notes and News" section, recounts personal items, honors, deaths, travels by physicians, and other matters, such as the fact that noted author Aldous Huxley was taking 0.4 grams of pure mescalin and was "moved" by its remarkable effect.

"Perhaps is Your Nerves" was another regular department that contained news concerning mental illness. This was discontinued when Dr. Robert Kimmich moved to the mainland. "This Is What's New" turns up late material for the physician who must read and run. Any subject

from the life span of a platelet to the effect of aspirin upon the gastric muscosa may be considered here. For some time the JOURNAL contributed a regular promotional page to the HMSA.

And from the sometimes wryly edited "Reports and Snorts": "A mistress has been defined, not unreasonably, as something half-way between a mister and a mattress." Also from the same department: "The long German word for a little glass tube is Rotblutkorperchensenkungsgeschwindigkeithestimmungsapparat — literally red-blood-corpuscle-sinking-speed-determination-apparatus."

The JOURNAL encourages contributions from members. It lists advertisers alphabetically under the title: "Our 'Angels'." Pharmaceutical advertising fell off in 1960 and the angelic qualities of the advertisers became increasingly apparent, although the ads were scrutinized no less rigorously than before. The year 1960 also saw the beginning of the Publications Committee, and it marked the beginning of the valuable series of Infant and Maternal Death Case Studies. That was the year, as well, that the Editor criticized a section of the Food, Drug and Cosmetics Act which he believed nonsensical. The Act, among other things, forbade certain ingredients in lipsticks because they have been found to induce cancer in rats. "Just warn the public against eating four or five lipsticks every day," the Editor, in effect, advised.

In 1963 a doctor of Hawaii fluttered the dovecotes with a JOURNAL paper suggesting that high school football was 13,666 times more dangerous than coal mining, "the most hazardous American industry." He said there was a near hysterical disregard of the dangers of the game in Hawaii. Several other doctors, only a few weeks ago, looked with some favor on high school football as a body and character building endeavor when they appeared on the Hawaii Medical Association's five-year-old TV program "Call the Doctor," aired weekly over Channel 13.

The Editor expressed the view that the purpose of the sometimes free-wheeling President's Page—with a regular message from the current head of the Association—was to permit the President to present "whatever message he may have, whether it represents policy already adopted, or the reverse, or neither, and regardless—good taste, punctuation, and syntax excepted—of whether the Editor approves of it or not."

When a feature has run its course, the editor has no hesitancy in dropping it. Summaries of medical papers printed in Interlingua beginning in 1957 were dropped in 1960, perhaps because of a scarcity of Interlinguists.

Throughout the years the JOURNAL has displayed an astonishing variety of interests and attitudes and a meticulous regard for the English language. A bristling editorial on "flossy medical terminology" appeared in 1948—one reason, perhaps, for the readability of the JOURNAL as compared to certain other technical publications. That standard, set early, has been maintained by the Editor who now has rounded out a quarter-century at a time consuming and relatively thankless task.

That Editor is Harry L. Arnold, Jr., the son of Dr. Harry Loren and Meda (Sheldon) Arnold. The senior Arnold was one of the physicians who acted in the Pearl Harbor emergency. Arnold, the son, was born in Owosso, Michigan, August 7, 1912. His family came to Hawaii in 1919 and young Harry graduated from Punahou School at the age of 15 and went back to Michigan for further schooling. He won an A.B., *cum laude,* at the University of Michigan in 1932, an M.D., also *cum laude,* at the University of Michigan Medical School in 1935, and an M.S. in dermatology three years later.

An internship at the University Hospital, Ann Arbor, Michigan, was followed by a residency in dermatology completed in 1939. Then he returned to Hawaii to join the Straub Clinic. He has five children and seven grandchildren.

An absorbing interest in leprosy has led to world travels to many congresses and conferences on the subject. He prefers the word leprosy to Hansen's Disease. His bibliography of more than 125 medical publications has given him an international reputation. He is a corresponding editor for the Pacific Area of the *International Journal of Leprosy* of the International Leprosy Association. He has been twice director of the American Academy of Dermatology and Syphilology and a member of the organization's Publication Committee.

Other professional society affiliations include the Society for Investigative Dermatology, the American Dermatological Association, the American College of Physicians, the Sociedad Cubana de Dermatologia y Sifilografia, the Associacion Argentina de Dermatologia y Sifilologia, the Sociedad Mexicana de Dermatologia (Honorary), the International Society of Tropical Dermatology (Vice-president, 1961-64) and the (brace yourself) Sociedad Venezolana de Dermatologia Venereologia y Leprologia. Add the American Academy of Dermatology (Vice-president, 1965), the Pacific Dermatological Association (Board of Directors, 1964-65), and the American Medical Writers Association. And he was Chairman of

the AMA Section on Dermatology, 1964-65, as well as Secretary of the Section on Dermatology of the AMA, 1956-61.

Honorary and other fraternal organizations include Zeta Psi, Mimes Club, Friars Club, Nu Sigma Nu, Vietor Vaughan Historieal Soeiety, Galens Club, and honor soeieties Alpha Omega Alpha and Sigma Xi, and Phi Kappa Phi.

Other medical organizations include the Blood Bank, the Oahu Health Council, the Mental Hygiene Association, the American Cancer Soeiety, and the Hillebrand Soeiety for Medical History. He has been a director or president of most of these organizations and was ehairman of the Publie Health Committee of the Honolulu Chamber of Commeree. He served on the Board of Medieal Examiners, where he was Secretary from 1960 to 1963, and has been a member of the Hansen's Disease Advisory Committee of the Health Department from 1950 to date.

Do such chores leave time for hospital aetivities? Well, Dr. Arnold was on The Queen's Hospital active staff, outpatient service, about half of each year from 1940 through 1955. He has had the same serviee at St. Franeis Hospital, plus teaehing dermatology to nurses from 1950 to 1955. He is on the Kuakini Hospital courtesy staff, a eonsultant in dermatology at U.S. Tripler General Hospital (sinee 1949), was Chief of Dermatology Staff at Queen's, and is Consultant in Dermatology to Kula Sanatorium, Lanai Hospital, State Hospital, Shriners' Hospital, Leahi Hospital, and Kauikeolani Children's Hospital.

He served as President of the Honolulu County Medieal Society for the 1949-50 term and of the Hawaii Territorial Medical Assoeiation for 1951-52. Since 1942 his record of professional eommittee work shows continuous and arduous aetivity. He scrved on the planning and program eommittees initially. There was further servicc on the Committees on Medieal Economics, Publications, Forms of Medieal Practiee, Library, Malpraetice, Constitution and Bylaws, and the Parliamentary Committee. In addition he manages to attend about eight out of ten of the monthly meetings of the Honolulu County Medical Society every year.

Despitc all this, time rcmained for lay activities, including presidency of the Hawaiian Aeademy of Scienee in 1952, sessions with Club 15, and frequent gatherings of the Honolulu Winc and Food Soeiety, at which members may bc expeeted to taste the broth and remark: "This is good soup, very good soup, but not a GREAT soup." The Honolulu Press Club, the New York Academy of Seience, and the American Association for the Advancement of Science offer certain other time-consuming activities. Dr. Arnold was elected a Fellow of the A.A.A.S. in 1957.

In the July-August, 1952, issue of the JOURNAL appeared an article under Dr. Arnold's byline on the indispensability of stress. The Editor noted that all living things are benefited by moderate stress but harmed by too much or too little of it.

Two and one-half decades of unremitting labor in many fields of medicine and community activities on the part of Dr. Arnold, while he also oeeupied the editorial ehair of the JOURNAL, would seem to indieate more than moderate stress on his part. Yet, in addition to such activities, he has become expert in such hobbies as nature lore, equestrianism, bridge, oenology, high-pressure chess (he colleets chessmen), the art of cooking brioche and other breads, and somehow finds time to pursue the byways as well as the highways of literature. He is an etymologist; will argue whether gravity is a push or a pull; and is prone to denunciation of those who assert that the eadueeus, emblem of Hermes, is a symbol of the medical profession.

His literary preferences? He admits to being a compulsive reader. He is apt to be found with copies of Herodotus, science fiction, Thoreau, whodunits, Guizot, Gilbert and Sullivan, Bernard Berenson, Stephen Potter, Kant, *The Annotated Alice,* and *Dorland's Medical Dictionary* stacked on his tables at the same time. For his notes on Dorland's Dictionary, see the book review section in this issue of the JOURNAL. He is an aficionado of the works of George Borrow, especially *Lavengro* and *The Bible in Spain.*

An interest in people, a prime quality in an editor, is present to an unlimited degree in the editor of the JOURNAL, together with a lively social conscienee. In world travels to seientific meetings he has been known to go miles out of his way to see former colleagues, old friends, and even relatives and friends of sueh associates.

A quotation from the raffish but scholarly humanist Francois Rabelais might point a moral:

> Wisdom entereth not into a malicious mind, and science without conscience is but the ruin of the soul.

The editor of the JOURNAL has wisdom without malice; he is a scientist with a eonscience.

---

With a deep sense of humility and gratitude, born out of appreeiation of 25 years of devoted serviee as Editor of the HAWAII MEDICAL JOURNAL, the members of the Hawaii Medical Assoeiation take great pleasure in dedicating this Silver Anniversary issue to the Editor, Dr. Harry L. Arnold, Jr. ■

HMA Public Relations Counsel.

# R Paradise Practice .25 Century
# Caps 1
# Sig. Take with grain of salt

ROBERT AND MARIE FAUS, M.D.'s, *Honolulu*

CHANGE HAS BEEN the most outstanding characteristic in medicine in the years from 1941 to 1966. At first, these were war years and so new ways and new practices were adopted much faster than ever before. For instanee, 95 per cent of Hawaii's population joined the 100 per eent of the military forces to receive typhoid fever immunization. The experiment in immunology had never been equalled by a eivilian community. No typhoid infeetion oeeurred until 1966 when one new case was diagnosed.

By 1941 the wonders of the previous 20 years had become useful tools to everyone. Banting and Best's insulin was in every office and long-lasting modifications eagerly welcomed, with oral products still a hope. Liver extraet was substituted for Monet and Murphy's raw liver which had so magically treated pernicious anemia, and the bottles of B12 were in every office to help with the therapy.

Hans Berger's eleetroencephalograph was not here, but its use was antieipated and later realized. Lungs had been removed elsewhere for cancer, but we were not that advaneed, though Alton Ochsner had been here to warn us personally. Malaria was considered for syphilis but was rejected.

Now came the wonder drug, suphanilamide, and its derivatives discovered by Dornogk. They were used extensively. The first case of Bubonie plague on the Hamakua coast was treated and reported eured by a sulfa ealled Gantrisin. "Sulphas" were tried for everything. Solutions were put into eyes, even irrigated into wounds. Its ointments were applied to cuts, burns, and infections. Then allergy struck and the use of the new magic dwindled as President Roosevelt's huge multi-million dollar penicillin plants began to furnish for the Army and the populaee that truly life-giving wonder.

DDT was announced by Paul Muller and we all had hopes of clearing out inseet-borne diseases permanently. At this time, it is true, the last dengue epidemic Honolulu suffered from was distributed by our energetie black and white Aedes day mosquito that has not been baek to repeat its performanee.

Lawrence in California had built his cyclotron and the atom was being worked on while bold surgery of the open heart and large blood vessels was reported.

Our Blood Bank was a going institution furnishing fabulous quantities to eivilian and military alike, while studies of its benefits and dangers were recorded. The Rh faetor was diseovered.

Now came the use of effeetive isoniazides streptomyeins in the ever-present battle against tuberculosis bacillus while a whole collection of antibiotics was presented. Aurcomycin, Declomycin, Chloremycetin followed, and we almost prescribed three blind myein in our confusion of wonder and hope. The blue-ehip stocks of the drug eompanies benefited almost as much as the patients from the new drugs. The tetracyclines even made our teeth glow.

The doctor's fee was neglibible compared to the astronomical cost of his remedies. A capsule that cost less than a dollar was cheap while $20 injeetions were gladly paid for, especially by patients seeking to delay the ravages of age.

The miracle of cortisone with rheumatism was uncovered by Hench and Kendall, and heralded throughout the world to give hope to thousands everywhere. Steroids proved to be a double-edged sword.

The character of the medical profession itself was as markedly altered as its methods when over 300 local men returned from war and from colleges with training in both. Clear eyed and fearless, these new M.D.'s expected installed

modern equipment. Specialists were developing and prospering in proportion to the drugs. Nose and throat men turned in the highest income reports, with surgeons close behind. Academies were formed and the requirements the profession imposed on itself were tremendous. Even the family doctors, the general practitioners, formed an academy in which each one had to turn in 50 postgraduate hours a year in order to remain on the roll.

Specialists in all sorts of allied skills made their appearance too. Psychologists vied with naturopaths, physiotherapists with osteopaths, and so on. Medicine here as elsewhere became a commodity and insurance companies developed programs designed to help pay the bills. The doctors themselves often underwrote the scheme in hope of retaining control of their own work. Our paternal plantations found themselves with medical programs that were becoming increasingly costly. The unions brought medical care costs to the bargaining tables. It was a different world.

Blood became synonymous with life as in Biblical times as even Tiseligs' electrophotisis became usual hospital procedure. Chemistry was the land of romance and one needed to know the difference between "osmolarity" and "osmolality" or be embarrassed at the examination for licenses. The young ones knew, and the rest could get 20 years behind in a brief five years. We ran to stay where we were and it had us breathless most of the time.

Electrolytes, hormones, and enzymes had to be the concern of everyone. Isotopes were used to tag the tell-tale molecules and inform us as to their whereabouts. Expensive tracing machines were first used and lent by our good neighbors, the armed forces at Tripler. Soon the civilian doctors took them up and tracings can be ordered from our independant radiologist specialists. Hormones and counter hormones filled the medical reports and were reported in the magazines and newspapers. Ferdinand Cori and his wife reported an insulin controlling hexokinase.

Chemotherapy was advocated even in the treatment of mental patients. The thiazines proved to be most valuable in saving the time of our overworked psychiatrists. Much that was good seems to have resulted from the use of this and related drugs. The number of patients in the State Hospital remained constant while the population of the islands doubled. Tales of use of the new DMSO and LSD were heard, but no real reports were ever published. The experimenters did not even talk to each other. Tranquilizers flooded our market as elsewhere.

Krebs explained his citric acid cycle and it was published even in simple nutritional handbooks.

Salk developed his vaccine with the help of the team (Enders, Muller, and Robbins) that grew polio virus on tissue of human and monkey origin. Mass immunization was offered the public by our county medical societies in 1961. Although not so well accepted as the typhoid program had been, polio became a matter of history not diagnosis. There were only 61 paralitic cases in all of the United States last year.

Diabetes was so complicated and prevalent that classes were organized in the clinics and hospitals to teach the patients how to keep themselves alive. Sugar in urine or blood alone was not our yard stick. Tolerance tests were given to those of suspicious ancestry and build. "Prediabetics" were diagnosed. Liver efficiency tests, even liver biopsies, became daily hospital procedure. The lifesaving measures that have been developed in the treatment of diabetes are now responsible for an ever-increasing number of diabetics in our population.

Catheterization of hearts was advocated, though no doctor had such an operation performed on himself. Hearts were repaired with gratifying success. The great Blalock himself, came to endear himself to us all and awe us with his accomplishments. With care and skill x-rays outlined and visualized aneurysms and anomalies. Even malignancies were accurately located. A washing-machine-like dializer after being primed with a bucket of blood could wash the urea or the barbiturates from persons able to undergo such an experiment. The noted Scribner from Seattle related to us personally his success and his heartaches at not being able to treat more. In the intimacy of the luau and the cocktail lounge, we have known and loved these great men more often than any other group in the world could have. We lured them with our climate and hulas, charmed them, and listened with spellbound attentiveness to their stories while everybody deducted the whole expense from their income taxes. Their portraits hang on the wall of the Mabel Smyth Memorial Building to renew our memories.

Anesthetists gave way to anesthesiologists as ether, chloroform, and ethyl chloride were replaced by other drugs. Pentothal went into veins, and novocaine into spinal canals. Vaporization developed. Pain even in childbirth was not tolerated. Our operating rooms were built with dials in the walls to show the electrocardiograms and blood pressure, continuously. Anesthesi-

ologists became important members of the doctor team.

Pathologists as well as radiologists became specialists in their own right. Patients sometimes feel that they are being treated by a committee instead of by an artist, as we used to hope they would. The laboratory is a complicated machine shop as robots check off blood counts, perform paper chemistry, and fix and freeze suspicious material from an operating table with speed and accuracy.

Not all has been success in our stimulating years. Allergics and side effects made many of the protective drugs instruments of death. The hospitals themselves with the antibiotics' help grew a fine species of staphylococcus that destroys as well as, or better, than the original did, and it shares its knowledge with our shigella bacillus. Our cells have been studied as never before as processes too minute to see are interpreted by our fine electronic microscope on the University grounds. Even diagnostic chromosome counts can be made here. When our new school of microbiology is further developed, we hope for much more. We were too far away to receive the terrifying samples of thalidomide but we do have rubella, for which an effective vaccine has been developed and, hopefully, will soon be released by the FDA.

Fine intern and resident training is still being continued and six of our hospitals join in the task. Where five men were considered adequate, now 50 do the work and they are now really paid a living wage for it too. New intensive care units are gratefully used by all with satisfaction while our signal 500 echoes clear to St. Peter's gate.

Genetics is our most stylish course though the University of Southern California heroically and expensively "refreshes" us each year. So far, we have synthesized no nucleic acid or hormones and are not being recommended for Nobel awards, though we do keep excellent and honest records of malignant neoplasm cases of all varieties. We already have the faculty and the millions of dollars to make the University of Hawaii Medical School a real educational center.

We hope we are prepared for the next 25 years as we were for the war, but it may be that, equipment notwithstanding, we can be caught with our genes down. ■

237 Portlock Road.

Give to the

ALOHA UNITED FUND

★

DON'T BE A FREELOADER!

Give your "Fair Share"

# Progress in Dermatology

HAROLD M. JOHNSON, M.D., *Honolulu*

THE ANTIMICROBIAL drugs have had unusual advances during the past 25 years (1941-1966), whereas before this era the sulfonamides were the remedies of choice. Penicillin finally became available about 1944 and proved to be most effective in treating many dermatoses, although previously it was used mainly in syphilis. The antibiotics list has rapidly become long and cumbersome, but quite effective.

Dermatology has been able to use corticotropin (ACTH) and the cortisones with profound effects on many disease processes. These agents do not appear to cure; their action seems to be a modification of cellular activity or permeability so that "toxins" no longer affect the cell. The steroids are of value for short-term diseases, such as contact dermatitis, and even for the more lethal ones, such as lupus erythematosus.

Liquid nitrogen at 396° F. and liquid oxygen at 297° F. have replaced dry ice to treat warts, keratoses, and benign growths. Dillaha and his group have recently treated cases of actinic keratoses and basal and squamous cell carcinomas of the skin by applying 5-fluorouracil (20 per cent) in hydrophilic petrolatum. The results were satisfactory in actinic keratoses and superficial intradermal malignancies. This is indeed a new age of topical chemotherapy in skin cancers and precancers. Hawaii physicians have used with gratifying results one per cent 5-fluorouracil in propylene glycol.

The single most striking recent advance is the advent of griseofulvin, an oral antibiotic specifically effective against certain superficial fungus infections of the skin, hair, and nails. The side effects of the drug are minimal. Tolnaftate in cream and liquid form is indicated for treatment of superficial fungus infections of the feet, groin, body, and hands.

In 1941, a sulfone known as Promin was first prescribed as a treatment for leprosy. The initial trials were encouraging. Careful investigative efforts resulted in the observation that sulfone therapy, although not an ideal form of therapy for leprosy, was superior to Chaulmoogra oil. Sulfones are now the treatment of choice for leprosy.

A review of recent literature reveals an impressive volume of new developments in basic science and clinical and therapeutic aspects of cutaneous medicine. The demonstration of a "reservoir" in the stratum corneum and of significant percutaneous absorption after the topical application of corticosteroids is one example. Another is the derangement of porphyrin metabolism in guinea pigs, and perhaps in man, following ingestion of griseofulvin. There are the new clinical variants of erythropoietic protoporphyria. Chloroquine neuromyopathy is a reported complication. Axillary hyperhidrosis is approached by simple surgery. The greater susceptibility to primary irritants of children as compared to adults is reported. Bithionol, a bacteriostatic agent used in many toiletries, has been found responsible for contact dermatitis and phodermatitis. Immunologic competence of peripheral leukocytes in delayed hypersensitivity has new methods of demonstration. The Praunitz-Kustner transfer antibody in the beta2A globulin fraction of serum is noted. Peculiar coagulation defects in epidermolysis bullosa have been found to have a lupus erythematosis syndrome which shows characteristic serologic abnormalities. Cataracts were associated with alopecia universalis. Malignant papulosis has been associated with severe central nervous system involvement. Cryoglobulins were found in acrodermatitis chronica atrophicans. The virus of milker's nodule was successfully isolated. Humoral antibodies were demonstrated in molluscum contagiosum.

It is both fascinating and gratifying to contemplate the tremendous progress which has been made in dermatology in the past 25 years. The intellectual surface has been barely scratched.

The folic acid antagonist amethopterin (methotrexate) is being used increasingly in the management of widespread psoriasis which does not respond to topical therapy. The principal contraindication to the use of this drug is pregnancy. The patient is carefully evaluated by kidney and liver function tests, complete blood counts. The drug is well tolerated for long-term use. ■

Alexander Young Bldg.

# Surgical Advances in Hawaii During the Past 25 Years

JOSEPH E. STRODE, M.D., *Honolulu*

WHEN I LOOK back twenty-five years to the day of the bombing of Pearl Harbor and the number of lives that were lost then that could now be saved given the opportunity of using our present facilities, I realize the progress surgery has made during the intervening years. Unquestionably the greatest advancements locally and elsewhere, judged by the saving of the greatest number of lives, have been:

(1) The establishment of a blood bank where unlimited amounts of blood can be obtained without delay.
(2) The perfection and safety of various types of anesthesia and individuals trained in their administration.
(3) The discovery and widespread utilization of antibiotics.

My having lived through the period when none of these modalities was available to the surgeon, permits me to evaluate their lifesaving potentialities more fully than can those who have entered the profession in more recent times.

Not long after my arrival in Hawaii some fifty years ago my closest friend, and the one responsible for my being in this part of the world, underwent a gastric resection. In the postoperative period he had a severe hemorrhage. No method was available for determining his blood loss, but the cadaverous expression of his face, the paleness of his skin, and the rapidity of his pulse left no doubt as to its alarming extent, or to the possible fatal outcome of an exploratory operation. In spite of liberal injections of caffeine and other equally noneffective stimulants, he pulled through because of his rugged physique. What a great asset our blood bank has been under many similar circumstances since that time.

Observing well-trained anesthesiologists in action these days, with all the various anesthetic agents at their disposal, the meticulous training they have had in their use, the amount of paraphernalia at their command for the comfort and safety of the patient, reminds me by sharp contrast of the times I functioned in a similar capacity during my internship days. Strong restraint was necessary to keep the patient on the operating table and I was never quite certain whether the victim was about to succumb from the anesthetic or was plotting how or just when to jump off the table and disappear down the hall as some of them nearly did. Under such circumstances, one needs little imagination to appreciate the difficulties of surgery, particularly in the abdomen where muscle relaxation is such an important factor.

The use of antibiotics, as we all appreciate, has added greatly to the safety of surgery and the welfare of the patient. Many diseases, such as osteomyelitis, lung abscesses, empyema, mastoiditis, and others, seldom come to the point of needing surgical attention.

Undoubtedly, the most spectacular advance in surgery itself during the past twenty-five years has been the successful dealing with afflictions of the heart and large blood vessels. The first successful open-heart operation in Hawaii was performed on December 2, 1959. In my early years of exposure to surgery, the chest and its contents were considered inviolate. With the development of endotracheal anesthesia, the perfection of the heart-lung machine, a better understanding of the physiology of the structures within the chest, and better diagnostic methods, as well as other ancillary discoveries which make all types of surgery much safer, the last remaining citadel, the heart, has capitulated.

Aneurysms of the aorta, until a few years ago beyond the pale of the surgeon's scalpel, are now being removed with ease and safety to the patient, providing longevity and comfort to many individuals. Occluded arteries, particularly to the lower extremities and to the brain, are being cleaned out or replaced, thus preventing leg amputations, severe brain damage, and death from anemia of the brain.

There have also been tremendous advances in the field of orthopedics, particularly in the treatment of fractures. While the newer antibiotics have largely relieved the problems of osteomyelitis, and the Salk and Sabin vaccines have almost

eliminated the orthopedic problems associated with poliomyelitis, ravaging disease of the young, the jet age of travel (particularly as related to the automobile) has increased the responsibilities in the field of trauma, especially in the treatment of fractures.

In my early years in medicine we were taught that the body abhorred foreign bodies as the devil hates holy water, or nature a vacuum. In recent years certain metals such as vitallium, titanium, and the like have been found to be well tolerated by the human body. The first time I ever heard of the use of a metal in the treatment of fractures of the hip was in 1930, when I heard Smith Peterson of Boston describe his nail in the treatment of such fractures. Most of his audience, I am certain, thought anyone using such a device should be sued for malpractice. Within the last few years, particularly since World War II, the use of such metals has revolutionized the treatment of most fractures. Prostheses made of such metals have been widely used in the treatment of hip fractures, and intramedullary nails first used by Bohler and others in Germany have added greatly to the improved methods of treatment of fractures of long bones.

The otolaryngologists, while they have largely been deprived of surgery of the mastoid, have been active in the field of deafness. Microsurgery on the stapes now helps many people with conduction deafness.

In the field of gynecology, the use of Papanicolau's technique to detect premalignant cells in smears from the cervix has proven to be most successful, and if all women would avail themselves of this method of examination, cancer of the cervix would no doubt cease to be a problem.

The area of neurosurgery has seen many advances in recent years. Hypotension anesthesia has been of great assistance, particularly in enabling the surgeon to deal more successfully with cerebral aneurysms. Improved methods of treatment of epilepsy, Cooper's work on the diagnosis and treatment of Parkinson's disease, and radioactive isotopes to localize brain tumors, probably are the most important advances in this field of surgery. Metal plates to cover over wide areas of defects in the skull have also been of great benefit to many individuals.

The biggest advance in urology in the past few years I feel, has been the ability to visualize the vascular supply of the kidney. This enables more accurate diagnoses and provide a means for differentiating between benign and malignant tumors. Some cases of hypertension result from partial occlusion of the arterial supply of the kidney. This can now be diagnosed by renal arteriography, and many cases of hypertension have been cured by correcting this condition. Transplantation of healthy kidneys to replace ones that are diseased is being carried out with increasing success in certain mainland centers, but to date it is too complex a procedure to warrant widespread application. I do not doubt that in the not too distant future this lifesaving measure will be made available in Hawaii.

In the field of abdominal surgery, the use of radioisotopes, better x-ray facilities, better anesthesia, more accurate diagnoses, and the increased safety of surgery in this area have been the most outstanding advancements. Treatment of portal hypertension by vascular shunting operations and the recognition of vascular occluding diseases of the viscera have added new fields of endeavor in this area.

Surgery of the thyroid gland has undergone radical changes during the past twenty-five years. What a challenge a patient with hyperthyroidism presented to the surgeon in my early experience! Successful treatment of this condition, with practically no mortality, is now the rule. My first experience was with the injection of boiling water to destroy the gland. Then came ligation of the blood supply to the thyroid, followed by resection of the gland in stages, if a fatality had not already occurred. The introduction of the preoperative use of iodine by Plummer in the early 1920's was a great step forward. Then came the thouracils, and now we have $I^{-131}$, both useful in diagnosis and treatment. Hyperthyroidism, formerly a disease with a high mortality regardless of therapy, is now cured with as little discomfort as swallowing a glass of water. When surgery is considered advisable it can be accomplished with a low mortality.

While for many years a limited amount of plastic surgery has been performed in these islands by various surgeons, no one well trained in this specialty and limiting his practice to this field was available until the late Dr. Merton Mack completed his training in the early 1950's. Some of the newer procedures being used by plastic surgeons today include facial nerve grafting; reconstruction of missing digits; and the use of neurovascular island pedicle flaps in which a piece of hand skin, with its nerve and blood supply intact, is moved from a less vital area to a more vital area to improve the over-all function of a damaged hand. One of the greatest boons to plastic surgery has been the perfection of the electrically driven dermatome to rapidly remove large pieces of skin for grafting. Less vital, but equally important to the individual needing such attention, is plastic surgery for cosmetic measures.

Another advance in recent years in the care of all types of surgical patients has been the establishment of postoperative recovery rooms and intensive care units. The recovery rooms completely equipped with devices to assist in the patient's immediate postoperative care and staffed by nurses especially trained in this type of nursing care, are adjacent to the operating rooms and allow anesthesiologists to be quickly summoned to care for emergencies that often arise during this period. They have been responsible for eliminating many complications and saving many lives.

Intensive care units are equipped in like manner to care for all types of emergencies, medical as well as surgical, and patients may be kept there as long as this critical period continues. Again, such units have been found to be a great step forward in the care of the critically ill patient.

In such a review as this, one should not fail to mention chemotherapy in the treatment of malignant conditions, even though results have fallen short of original expectations. While no one claims that this method of therapy is often curative, it has frequently been found helpful in controlling the spread of malignant lesions and in prolonging life. Those interested in this method of treatment are hopeful that new drugs will soon be available which are less toxic and more curative.

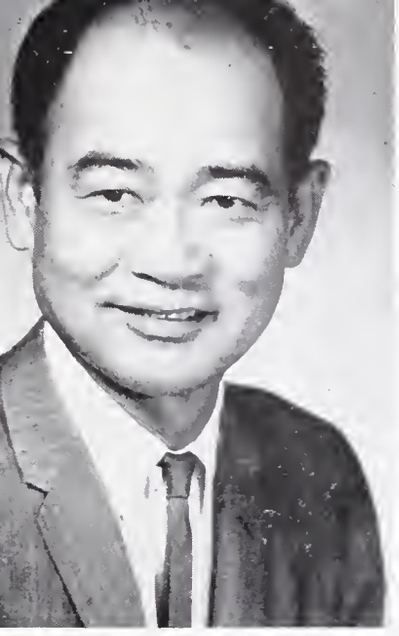
Looking back at the advances that have been made in surgery during the past twenty-five years in Hawaii, the most outstanding and spectacular have been in surgery of the heart and arterial tree. Because of its newness and its being surrounded by an aura of dramatic accomplishment, it has tended to entice the young surgeons to devote a great deal of their time and energies to becoming proficient in this field. I am afraid that many of our young surgeons returning to Hawaii may find that they have been overtrained in an area that has a comparatively limited field of application. This is why, to me at least, the greatest advances in the last twenty-five years in surgery locally and elsewhere have been in the things that can be used by the greatest number of surgeons for the good of the greatest number of individuals—the value of our blood bank, the availability of a number of well-trained anesthesiologists, and the application of antibiotics. No doubt the next twenty-five years will bring advances in surgery that may well dim what has been accomplished over the past twenty-five years. Organ transplantation is still in its infancy. While no doubt this will claim the full time and attention of many of our brightest young surgeons, I hope they will not neglect the problems in other areas which are widespread and which affect many of Hawaii's inhabitants.

In this brief résumé of recent advances in surgery, local priority cannot be claimed for much that has been accomplished. With the development of a new medical school in Hawaii and more interest being shown in problems requiring research in their solution, no doubt the next twenty-five years will result in greater credit for originality being given Hawaii than has been received in the past. However, I am convinced that the surgeons of Hawaii have brought to the citizens of these islands all the advances in our profession that can be applied in a practical manner for the benefit of its inhabitants. ■

888 So. King St.

---

Normally every line of type in the HAWAII MEDICAL JOURNAL is scrutinized by the Editor. This section of this issue has escaped this scrutiny. The Editor cannot be held responsible for typographical errors, lapses in grammar, factual mistakes, or occasional use of "irregardless."





# *The President's Page*

Soon after taking office in May, I had to make several trips to the mainland—to Washington, D.C., for the AMPAC Conference; then to the Presidential White House Conference on Medicare; and finally to the annual AMA meeting in Chicago. Therefore, it was July before I was able to complete the change of our structure to the commission form of organization. Formerly, each member of the Council was responsible for a certain number of committees. However, the members of the Council, being elected, were not directly responsible to the President. In the commission form of organization, each Commissioner is appointed by the President and he is directly responsible to the President—as a Cabinet member is to the President of the United States. Each Commissioner is responsible for a certain number of committees, and with this direct line of communication it is my hope that better liaison can be established between various committees and, ultimately, with the general membership. I recognize that breakdown in communication is one of our major obstacles whether it be a county society, or state organization. All avenues will be explored to improve lines of communication, for fast-breaking events make it mandatory that we maintain closer unity and harmony.

With the inception of Medicare numerous acute problems came to the fore. For example, the problem of direct billing by hospital-based specialists, and another one that is unique in Hawaii, i.e., the problem of reimbursement of remuneration received by plantation physicians under Part B of Medicare back to the plantation. Our Council took appropriate and strong action on both problems on the ground that it is illegal for a corporation to practice medicine in Hawaii.

Most physicians are familiar with Title XVIII of the Medicare Law, but have shown little concern for Title XIX, which is an expansion of Federal grants-in-aid. This portion of the bill has more far-reaching implications than Title XVIII, for there is no age limit under this section of the law. Also the coverage is more comprehensive; it even includes drugs and prosthetic needs.

In our State there are about 28,000 indigents, of whom over 2,000 came under Title XVIII. The remaining 26,000 may qualify under Title XIX. During the last legislative session I testified in the Senate Ways and Means Committee that our Association had established a relative value study based upon an actual survey made of our members and that this organization stands on the principle of free choice of physician and the fee-for-service concepts. The Hawaii Medical Association and the Department of Social Services were instructed to negotiate whether this concept will be feasible on neighboring islands and rural Oahu. The Medical Care Plans & Fees Committee has promulgated a concept of subsidy for the fiscal year ending June 30, 1967, and your Negotiating Committee has met with various government agencies on several occasions.

With the Federal, State, and local governments taking a paternalistic attitude, the officers and Council members felt that while patients may be indigent, the government is not, and physicians should no longer be required to subsidize indigents' medical care. I recommend that all of you charge your usual and customary fees, and keep an accurate account of the amount of subsidy you have been providing.

Our biggest obstacle in our negotiations with governmental agencies and Workmen's Compensation Bureau is that we have been submitting fees prescribed by the agencies and not our usual, customary fees.

You have already witnessed the beginning of socialization of medicine and with each session of Congress you can only expect further broadening in the scope and benefits of care.

We must stand united or we will be divided and conquered!

Theodore Tomita, M.D.

HAWAII MEDICAL JOURNAL

# Editorials

## Reppunzel, Reppunzel, Put Up Your Hair!

"Fluoridation is dead," said Dr. J. I. F. Reppun in his column in a recent issue of the JOURNAL—a fairy tale, told with hair let down as far as that of the legendary Rapunzel, who also lived in a (nonivory) tower.

Fluoridation is dead? Some corpse! It is currently benefitting some 60,000,000 Americans, in 3,000 U.S. cities. And despite the fact that it is—uniquely among public health programs—required to pass the obstacle of a referendum vote in many cities, it was approved last year in 28 out of 50 such votes.

We have failed to date, Dr. Reppun charges, to convince our legislators of the worth of fluoridation. Not so. One legislature actually endorsed it, in both houses, but Governor Sam King's veto killed it. Since that time, legislative approval has been withheld, but not because our lawmakers are not convinced of its worth. It is merely their natural instinct for political self-preservation where a noisy minority like the antifluoridationists is concerned. One of our ablest Senators—the Honorable Vincent Yano—is actually on the Board of Directors of the Hawaii Fluoridation Council.

Dr. Reppun claims "the right not to be done good to," even when the good consists of the prevention of a preventable disease which takes its toll of the entire community in terms of teeth and the cost of their repair. The need for such prevention in Honolulu is greater than that in almost any other American community—and America has some of the highest decay rates in the world.

"Why," asks Dr. Reppun, "should I suffer or pay for the inadequacies of others?" No suffering is involved—just ask any resident of San Francisco, or Chicago, or any of our many major cities which have fluoridation. And the cost of fluoridation will be paid back many times over by the reduction of the cost of present dental health programs, and dentists' bills. Taxes won't go up—at least, not on *this* account!

"Grossly exaggerated statistics," says Dr. Reppun—a phrase which suggests he has been reading what passes for "literature" among the antifluoridationists. A two-year joint study of fluoridation by the AMA's Councils on Drugs and on Food and Nutrition, including hearings at which they listened to spokesmen for both "sides," resulted in the AMA's unqualified endorsement of fluoridation as both effective and safe. Forty-seven other medical organizations have also endorsed it, including such responsible ones as the American Academy of Pediatrics, the American Dental Association, the Federation of American Societies for Experimental Biology, and the College of American Pathologists. If Dr. Reppun finds the evidence for its effectiveness unconvincing, he's pretty lonely.

"Why," inquires Dr. Reppun, "should we blanket the waters of the land with additives, for the sake of counteracting the effects of the carelessness, ignorance, or even the misfortune of a few?" A *few*, Dr. Reppun? Do you see children's mouths in your practice? Would you like to look at my teeth? Have you read the articles in the HAWAII MEDICAL JOURNAL reporting the shockingly high incidence of decayed and missing teeth in Hawaii's teenagers?

And what, please, do ignorance, carelessness, or misfortune have to do with tooth decay anyway? Would it help to legislate or persuade human beings to be careful? Or fortunate? Or informed? Will knowledge prevent caries?

If fluoridation is begun here, says Dr. R., "another link in the chain of socialism, the we-know-what's-good-for-you philosophy, will have been forged and another liberty lost." Well, in a way, he's right. We would have to drink nutritionally adequate water for a change—just as we have been forced for years to attend school, to drink pasteurized milk, to be vaccinated against certain communicable diseases, and to stop our car before entering stop streets. Infringement of

"liberty" for the good of others is hardly a novelty —and to resist fluoridation on this ground is an excellent example of what Ralph W. Emerson meant by his famous phrase, "a foolish consistency."

Fluoridation for the prevention of tooth decay is now known beyond any question, after 21 years of trial programs and many judicial reviews, to be effective, safe, cheap, legal, and moral. No one past the age at which he could reap its benefits personally has a moral right to resist its adoption for the protection of those who *are* young enough to be helped by it. Unless he has new evidence to offer before the court of public opinion—and his emotional reactions are *not* new evidence—his lips are sealed.

# The Declaration of Helsinki

Recent public scandals about clinical research projects in which patients hardly even aware that they were subjects of research were subjected to procedures they would probably never have consented to, such as injections of live cancer cells, or the withholding of medication of known prophylactic or therapeutic importance just to provide a control, have understandably led to tightening of FDA controls over clinical research.

It is perhaps just as understandable that the AMA should not want to be thought a laggard in this matter, and so its House of Delegates has endorsed the World Medical Association's 1954 "Declaration of Helsinki," a document with some fourteen guiding principles and a preamble.

In Part I, Basic Principles, the investigator is required to have a scientific basis for his work, and to have it conducted only by scientifically qualified persons and under the supervision of a qualified medical man; to be sure it is important enough to justify any inherent risk; and to use special caution if the experiment seems likely to alter the personality of the subject. One would trust so!

Part II enjoins upon the investigator-physician the responsibility of obtaining informed consent to the study, and justifying any investigative work entirely by its therapeutic value for the patient.

Part III, Nontherapeutic Research, charges the investigator with the duty to protect the subject's life and health; to explain all to him and get his fully informed consent; and to be sure he knows he can withdraw his consent at any time during the experiment.

Apart from the problem of who is to decide what constitutes a scientifically qualified person or a qualified medical man, and how he is to decide it, these guidelines seem reasonable and sound. Some of the recent lurid exposés would certainly not have been necessary or possible, had the investigators involved been mindful of these restrictions. Hopefully, the AMA's action may afford these rules wider circulation among those who need their guidance.

# Typhoid--Remembrance of Things Past?

Typhoid fever—now often designated by the scientifically dignified but dramatically flat "enteric fever"—is so intimately associated with great men and great events in modern scientific medicine that reminders of the essentials of its diagnosis seem an affront to the well-ordered medical mind. A cornerstone of practice in sanitation; prophylactic immunization; the elucidation of the carrier states; diagnostic serology; source of mottoes ("food, fingers, and flies") and of legends (Mary Mallon, cook and carrier, a public health classic, whose career, as "Typhoid Mary," makes the James brothers small-time operators); typhoid fever has engaged the attention of masters of medicine from Thomas Willis and William Jenner to William Osler, in whose textbook it was Chapter One.

The diagnosis of typhoid fever is clinical, but needs to be confirmed by laboratory findings. During the first three to seven days of the step-ladder fever, blood cultures positive for Salmonella typhi will provide the definitive diagnosis in 70 to 90 per cent of cases, proving the value of culture secured early in unexplained fevers. Consequent bacteriophage sensitivity patterns will afford the epidemiologist his best means of identifying the source of the infection independently of the patient's future treatment. Many have found the culture of blood clot to be of great value if the febrile illness has continued into the third week without positive cultural findings.

Of less definitive value but great presumptive significance is the appearance of flagellar (H) and somatic (O) agglutinins in the serum during

the seeond week, eontinuing to rise after the patient is elinieally well. The greatest value of these is in sereening suspeeted eases and earriers, sinee these tests are rapidly performed with early results available to the physieian. Generally, in pyrexia of unknown origin, H titers of 1:200 or over and O titers of 1:100 or higher are presumptive evidenee of typhoid fever. Inereased titers of Vi agglutinins are most useful in earrier states. The influenee of previous vaeeination, however, may influenee these results, more or less.

During the third week of the disease, stool and urine eultures will show the highest ineidenee of positive reeovery of typhoid baeilli, though seldom are reeovery rates over 80 per eent. As has been amply demonstrated, eountless variations may be eneountered. Stool isolations early in the disease or later, in the absenee of signifieant agglutinin titers; negative blood eultures, often due to presumptive ehloramphenieol treatment; or failure to develop agglutinins, all may be noted.

Old-fashioned elinieal observation with simple laboratory observations may be the physician's sole reliance. The stepladder fever with headaehe and drowsiness, leukopenia with relative lymphocytosis, splenomegaly, and rose spots, all point to the elinieal diagnosis and the need for eultural identifieation before treatment is begun.

DRAKE W. WILL, M.D.

---

## *The Political Credo of a Physician*

"...I always thought that as a physician I was helping people to get well, only to turn them into a community where the atmosphere created by government is not conducive to convalescence.

"It's a sick kind of system that discourages individualism and initiative and encourages dependency on government.

"The present trend in government is the dole—dole and dole and dole. The people don't have to make a decision. They don't have to go through the tensions of struggling. So, when they're faced with a crisis, they're lost. They've become too totally dependent.

"It's a sinister kind of thing. I'd like to help stop this kind of decadence." ▪

GEORGE H. MILLS, M.D.

# Hawaii Academy of General Practice

Every doctor's office should be a screening center for cancer.

Every general practitioner has the opportunity to screen his patients for every serious impending illness, and not just cancer.

We have an obligation herein that calls for service almost above and beyond the call of duty, in view of the fact that most generalists see a rather larger volume of patients than any other practitioner excepting the pediatricians. The large volume inescapably means less time per patient.

There are two main categories of patients that we generalists must keep in mind if we want to be known for more than just treating colds and sore stomachs: the new patient with a relatively minor complaint, and the old (in the sense of long time) patient whom we think we know inside and out, his relatives, his home, his job, his politics, and his religion.

Many of us have had the experience with the patient who comes in for a headache. Quite often, the receptionist takes the complaint for what it seems to be worth and allots a brief segment of the appointed day to such a patient. Not only is it a question of starting a complete history and physical, which, after all, could be rapidly and cursorily done. It may even mean that the patient is using the complaint to obtain ingress to appraise you. The real complaint may be more serious; or it might be masking embarrassment; or it may hide nothing more than a desire to obtain a complete and thorough evaluation.

More often than not, this patient has not had a thorough medical work-up for years; so, here is the golden opportunity for the doctor to probe gently at first, and as he gains the patient's confidence, to broach the subject of a thorough evaluation. Relatively few people will resist this suggestion.

The complete examination can easily be rescheduled, and it can be done fractionally; it need not be a very expensive, blind, run-the-gamut or battery-of-tests type of thing. A meticulous initial questioning, plus the stethoscope-and-hands sort of physical, can provide most of the leads for more extensive studies, and with the addition of the ophthalmoscope, otoscope, vaginal speculum, and proctosigmoidoscope, most of the gross screening can be done in the office. Most new patients will be well satisfied with a doctor who does *not* use only his stethoscope on shirted chests, and who at least rises from his swivel chair for the rest of the physical.

Now take an objective glance at the chart you have before you, probably a real fat file on some of your monthly or weekly returnees. Maybe it is just a routine check on a diabetic, maybe on a hypertensive. Do you have a ready way of quick-glancing to see when that last complete physical was done? Just because you know him or her so well is no reason to forget that a periodic screen is as much that patient's due as it is that of some newcomer to your practice. That patient also will be grateful for a gentle reminder: "Next time make an appointment for a longer visit, and we'll give you a complete going over."

Every doctor's office should be a screening center: Every kid that comes in because his coach wants a form filled out saying he can play football falls into a welcome trap, as far as his parents are concerned, if the doctor also checks his vision, hearing, height, weight, and immunization status. Hardly any medical health or insurance plans cover physical examinations, yet very, very few people hesitate to pay out of pocket for preventive medicine. We just don't do enough of it—maybe because it is boring to us and makes the office gang work too hard—but it is a rewarding form of practice to be able to pick up a strapping athlete *before* he becomes a high school senior with a long-time hernia that escaped notice for years.

People are funny. No matter how educated they may be to life in general and to things medical in particular, no matter how well you train them to take care of themselves and to take care of their own, they still prefer to let the doctor assume full responsibility for all medical matters —just as I like to leave my car at the service station and say: "Here it is, do what needs to be done."

We physicians are expected to practice in this way, more and more. The public is being educated to being screened *before* first symptoms appear; part of our besmirched modern image is the result of old-fashioned office techniques in this regard. ■

J. I. Frederick Reppun, M.D.
*Secretary*

HAWAII MEDICAL JOURNAL

# This Is What's New!

- There is a significant but low-level positive correlation between corpulence and **serum cholesterol** level. This is more evident among men than women and even though low, it is statistically significant. (*American Journal of Clinical Nutrition* [June] 1966).

- **Free fatty acids** may be more important in the **diagnosis of latent diabetes** than the level of the blood glucose. Early latent diabetes was characterized in one study by minimal abnormality of glucose tolerance, but marked elevation of the free fatty acid level after giving cortisone. (*Metabolism* [June] 1966).

- Under the title, "Is There a **Malignant Freckle?",** New Yorkers explore the evidence for it; there isn't. (Who thought there was?) [Hutchinson, Dubreuilh, and us—ED.]. (*Cancer* [June] 1966).

- Acute postinfectious polyradiculoneuropathy, the **Guillain-Barré syndrome,** is **not improved** by the use of **corticosteroids.** (*Schweizerische Medzinische Wochenschrift* [June 18] 1966).

- At the American Therapeutic Society in Chicago, the **mumps** vaccine was reported to be 98% effective in clinical trials carried out among pre-school and school children. (*Antibiotic News* [July 20] 1966).

- Handicapped drivers do not constitute an increased hazard in traffic as a group. However, the **accident frequency is greater** among drivers with loss of function of the **right leg** or **right arm.** (*British Journal of Industrial Medicine* [July] 1966).

- **Age** may increase the **ankle jerk time.** Contraction and relaxation time of the ankle jerk tends to become slower with age. Unilateral disease of the **corticospinal** tract **shortened the contraction phase** on the affected side, but did not change the latency or relaxation time on the affected side. Diffuse cortical lesions produced significant differences between the right and left sides. **Peripheral nerve disease** showed **no change** in latent time unless the peripheral damage was very severe. (*Archives of Neurology* [Aug.] 1966).

- A person who **laughs or cries** at the **wrong time** may have a **brain tumor.** The syndrome of inappropriate emotional response (pathological laughing or crying) has been described in a variety of central nervous system diseases. In the case reported from Boston, a meningioma ventral to the pons was responsible for the tears and laughter, and this inappropriate response was cured by surgery. (*Journal of Neurosurgery* [June] 1966).

- Rats, like humans, respond adversely to **chronic noise.** After prolonged exposure to noise levels that were felt to be analogous to those encountered by man in his day-to-day living in urban and industrial areas, white rats developed changes in levels of circulating **eosinophils,** adrenal and brain **ascorbic acid,** and serum **cholesterol.** There was no indication of physiological adaptation to noise as indicated by the paramcters measured. (*Archives Environmental Health* [June] 1966).

- In known sleepwalkers, it was found that the **walking** occurred during the **slow wave sleep** rather than during the rapid-eye-movement period associated with dreaming and faster EEG activity. Sleepwalking could be induced by standing the somnambulist up during a period of slow-EEG-wave sleep. (*Archives of General Psychiatry* [June] 1966).

- **Dagger Bank itch,** a rash appearing among North Sea trawlermen, is caused by a **seaweed-like organism.** Seven per cent of the fishermen exposed developed dermatitis. Patch tests with the seaweed were positive. (*British Medical Journal* [May 7] 1966).

- The **flatus factor** in **soy bean** products is being studied in Illinois. This factor is concentrated in low molecular weight constituents. Hulls, fat, water-insoluble polysaccharides, and protein were not associated with the flatus factor. When **Navy beans** were added to dehulled, defatted soy bean meal, the **flatus volume increased** 2.52 times. (*Proceedings of the Society of Experimental Biology and Medicine* [April] 1966). ■

FRED I. GILBERT, JR., M.D.

HAWAII MEDICAL JOURNAL

# In Memoriam – Doctors of Hawaii.....

This is the sixty-third installment of In Memoriam—Doctors of Hawaii.

## Vasco Eric Montier Osorio

Vasco Eric Montier Osorio was born in Honolulu on July 11, 1887, the son of J. A. M. (kamaaina Hilo merchant) and Marie M. Lesser Osorio.



DR. OSORIO

He was educated at St. Louis College in Honolulu and received his medical degree from the University of Louisville in 1916. The following year Dr. Osorio interned at St. Alexis Hospital in Cleveland, Ohio. In 1926 and again in 1937 he took graduate work in Vienna.

He began his professional work as surgeon for the Corrigan McKinley Steel Works at Cleveland. Commissioned in September, 1917, Dr. Osorio was called to active duty June, 1918, as first lieutenant in the Army Medical Corps. As assistant surgeon of Evacuation Hospital No. 15 at Verdun, he participated in the St. Mihiel and Meuse-Argonne actions. From 1918 to 1919 he served with the U. S. Army of Occupation, First Division, in Germany. He was discharged in September, 1919, with the rank of Captain.

After his discharge, Dr. Osorio returned to the Islands and established himself in private practice in Hilo.

In 1928 he married Miss Olga Marian Ortland in San Francisco. The Osorios had twin daughters, Marian and Marie.

From 1924 to 1943 Dr. Osorio practiced in Honolulu and was on the surgical staff at Queen's and Children's hospitals. Moving to Oakland, California, in 1943, the doctor practiced there until his retirement.

Dr. Osorio died in Piedmont, California, August 29, 1958, at the age of 71.

The doctor was retired from the Navy with the rank of Lieutenant Commander in 1955. He was a member of the Aloha Lodge A.F. & A.M., a Fellow of the College of Surgeons, and a member of the American Academy of General Practice and the Alameda County Medical Society.

## George Stephen Bliss

George Stephen Bliss was born on June 21, 1872, at Lebanon, New Hampshire, the son of Robert E. and Louisa A. (Lawson) Bliss.

He was a graduate of Dartmouth Medical School, Hanover, New Hampshire, in 1904.

That same year Dr. Bliss became assistant physician at the Massachusetts School for the Feeble-Minded, located in Waverly.

On June 18, 1907, Dr. Bliss married Elizabeth O. Hall at Boston, Massachusetts. Two daughters were born to the couple, Sylvia Mae and Katherine.

Moving to Maine in 1908, Dr. Bliss built and opened the Maine School for the Feeble-Minded in Pownal. In 1913 he was appointed superintendent of the Indiana School for the Feeble-Minded in Fort Wayne and served there until 1920.

On March 16, 1920, Dr. Bliss came to Hawaii as superintendent of the Waimano Home for the Feeble-Minded at Pearl Harbor. After six years in Hawaii, the doctor resigned his Waimano Home position to accept an appointment as superintendent of the state home for the feebleminded at Pomona, California.

Dr. Bliss died in May, 1941, very shortly before his 69th birthday, at South Pasadena, California.

He was elected President of the American Association for the Study of the Feeble-Minded in 1920 and was also a member of the Indiana State Commission to study mental defects. He was a member of the volunteer Medical Reserve Corps (although not called to active duty) and was legal advisor to recruits at Fort Wayne. Dr. Bliss was a member of the American Medical Psychological Society and the National Society for Mental Hygiene. ■

HAWAII MEDICAL JOURNAL

# Book Reviews

## Dorland's Illustrated Medical Dictionary, 24th Ed.

*By 10 Editorial Consultants; no author or editor names. Price $13.00. 1724 pp. Philadelphia & London, W. B. Saunders Company, 1965.*

THE LAST NEW EDITION of Dorland came out in 1957; it hasn't often gone eight years between editions. Newman Dorland is not the editor this time; ten editorial consultants produced this edition. The same format has been retained, and the same binding, and the same simple, vivid method of indicating pronunciations. Internationally official Nomina Anatomica terms agreed upon in 1955 and 1960 are used.

Hundreds of drug names are said to have been added or deleted in this edition. Why, if this is so, are not 5-FU, fluorouracil, FUDR, or betamethasone mentioned? Why is diamino diphenyl sulfone (Avlosulfon, DDS, or dapsone) not mentioned even under its trade names? Both Diasone and Promin, which it has virtually replaced, are mentioned, though only under their (mysteriously uncapitalized in all instances) trademarked names. Interestingly, "aristocort," "kenacort" and "kenalog" (uncapitalized) as well as triamcinolone are given, and so are medrol and methylprednisolone, and decadron and dexamethasone; but not Celestone Soluspan. And under triamcinolone, the intra-articular, intrabursal, and intrasynovial routes of injection are painstakingly detailed, with no mention of the intralesional or intramuscular routes.

The leprosy definitions are still a deplorable mess. Macular and maculoanesthetic leprosy are defined as "neural" leprosy—an expression which has been wholly obsolete in this sense for almost 20 years. The two types of leprosy, instead of being correctly designated lepromatous and tuberculoid, are wrongly said to be "(1) cutaneous, lepromatous, or nodular, and (2) neural or maculoanesthetic," and the next sentence adds, again wrongly, that "a combination of these types is called *mixed leprosy*." The silly, utterly baseless old canard about spontaneous amputation is repeated. "Leprolin," reasonably enough, has been deleted; but "lepromin," mysteriously, is gone as well, which is clearly an error; it needs to be brought back and its various types defined. It is needed particularly because the reader is twice referred to it—under "Test, Mitsuda-Rost" (who, incidentally, is this mysterious Rost?) and under "Test, lepromin."

"Cyst, sebaceous" is defined as "retention cyst of a sebaceous gland," which is probably better lexicography than pathologic physiology; the officially preferred term (cyst, epidermal) is not given at all. "Synovial cyst" is defined unexceptionably as "a distended synovial bursa or tendon sheath," but myxoid cyst is still missing, and Heberden's nodes are just "small, hard nodules."

Digitalis has become digi*tallis* instead of, as formerly, digi*tay*lis. Preauricular, formerly defined as "situated in front of an auricle," now is said to mean "in front of the ear." Epicanthic, as in epicanthic fold, was missing in 1947 and it is still missing: you have to choose between epicanthal fold, epicanthine fold, and just epicanthus. They had two choices out of three and muffed them both!

"Flatus" is still said to mean expulsion of air or gas only when it is applied to the vagina; in connection with the bowels, says Dorland, it merely means gas or air *in* them, and *flatulent* is stated—ah, how incorrectly!—to refer only to this state of affairs, not to its relief.

The change from "r" to "R" for the designation of the roentgen has been duly noted; amusingly, however, it has not yet filtered down to the milliroentgen or the microroentgen, both of which still carry the lower-case symbol. It is curious that, like all other designations of units, it is printed with a period each time it appears. Even simple symbols of chemical elements, and chemical formulas, are followed with a period.

The use of words like bronchoscope, gastroscope, and cystoscope as verbs, which is obviously here, and here to stay, is not yet recognized by Dorland; no Webster III permissivity for them! These are just nouns. Even x-ray is not acknowledged to be a verb; more than that, it is said to be obsolete—it is just "the name given by Roentgen to the rays now known [to whom?] as roentgen rays," though at the end of the definition of "roentgen rays" the grudging acknowledgment does appear: "Called also *x-rays*." There does seem to be a failure to appreciate the fact that medical English, no less than lay, grows and changes, and not always in the direction lexicographers think it ought to go. It may not be altogether irrelevant that the diagram explaining the structure of an x-ray (pardon *me*: roentgen ray!) tube shows, not a modern x—I mean, *roentgen* ray tube, not even a 30-year-old Coolidge tube, but a 50-year-old triode-type gas tube! You won't find this under "x" (there is no such entry) or even under "X" (this means just "Kienbock's unit of x-ray [tut-tut, gentlemen: *roentgen* ray, please!] dosage); it's under "ray, roentgen," on page 1287. Somebody has roentgenkater ("roentgen intoxication," whatever *that* might be!).

The Gräfenberg ring is correctly said to be named for Ernst Gräfenberg, but his name is listed separately as Grafenberg, without the umlaut. Neither Lippes, of loop fame, nor Margulies, equally known for his coil, is listed under either name or device.

In naming tests which bear their authors' name, or names, the editors evidence an inconsistent compulsiveness about apostrophes. They have no objection to Mitsuda test, Frei test, Fuelgen [*sic*] test, Kahn test, or Klein test, and almost all tests with hyphenated names get by without the possessive. But the majority of names of tests get an apostrophe, even when it leads to such awkward forms as Fuchs's test, Gies' test, Dicken's [*sic*] test, Brugsch's (shudder!) test, Falls' (why not Falls's?) test, and Coombs' test. Let us hope they will wipe out all these apostrophes the next time around.

Well, enough of this lovemaking; it is easy to pick faults, and one may hope that some of them will be noted and corrected in a future edition. There isn't any room left in which to pick unfaults; they are too numerous. As we said in 1947, this is still the same excellent and generally reliable dictionary we have all known for so long. After eight years, your old 23d edition—or your still older one—surely ought to be replaced. The next gap is likely to be at least as long.

HARRY L. ARNOLD, JR., M.D.

## ★Medical Care of the Adolescent, 2d Ed.

*By J. Roswell Gallagher, M.D., with eight contributing authors, 489 pp., $12.00, Appleton-Century-Crofts, 1966.*

THIS SECOND EDITION of this book, written by the initiator of the Adolescent Medicine movement in this country

*continued page 68*

★ means highly recommended.

HAWAII MEDICAL JOURNAL

# Notes and News

## Having a Liddle Fun with JAMA

EDITOR, *JAMA:*

I was greatly intrigued by a letter appearing in the July 25, 1966 issue of the *Journal* on page 300. It is entitled "How to be a Respectable Tramp." It is signed, "G. G. Liddle, M.D., Bloomington, Hawaii."

Upon inquiry at the Hawaii State Library, I learned that there is no such place as Bloomington, Hawaii. Further, questioning of the Hawaii Medical Association reveals no listing for an M.D. named G. G. Liddle.

Maybe some light might be shed if you would publish this letter. It just might be that the writer is a "respectable tramp" hiding under a pseudonym in some remote corner of our fair state.

PHILIP S. ARTHUR, M.D.

DEAR DOCTOR ARTHUR:

We, too, are concerned by the apparent pseudonymity of G. G. Liddle, M.D. We suspect that his "Bloomington" is a lean-to in the craters of Haleakala. We communicate with him by carrier pigeon released by a mutual friend of dark nights beneath what he says is a "milo tree" in the Honolulu zoo. It sounds mighty fantastic to us.

The last time we threatened to smoke him out he threatened back at us to write no more letters.

I wish I knew a way out of the dilemma. Thank you for your suggestion. In desperation, we may have to use it.

GEORGE L. FITE, M.D.
Letters Editor, *JAMA*

## Sportsmen

*Fishermen?* The 1st Annual HMA Fishing Tournament, organized by **Dudley Seto,** was held on that fateful May 14 Sunday. Five charter boats, manned by eager, stalwart souls who had gulped their Dramamine tabs, sailed gaily out of Kewalo Basin. In the late afternoon, these very same boats crept back laden down, not with fish, but with heavy hearts. The contest, however, was tight, for the three winners weighed in within a half pound of each other. **Garton Wall** squeaked through with a 26-pound mahimahi while **Larry Winter** had a 25¾-pounder and **Bob Peyton** a 25½-pounder. **Ed Taras** took honors for most fish with a 24-pound mahimahi and "countless" kawakawa. Never-say-die **Carl Lum** took the booby prize for smallest fish by pulling up a sergeant major fish less than 2 inches long with a bamboo pole from the Kewalo dock. At least he pulled up a fish. . . . The other participants were remarkably noncommittal. . . .

*Other fishermen:* It seems that **Phil Corboy** went fishing at Cabo San Lucas where he caught 12 mahimahi and two marlin (150 and 180-pounders) without gaining any points in the tournament. Too small, eh? **Dick Sakimoto** and **Luke Tajima** returned from a weekday overnight trip to the Banks with 400 dobey ulua, four rainbow runners and 15 ordinary ulua. At last report, Dick was paying people to take some of the fish off his hands. . . .

*Surfers:* We received an open invitation from Kaiser physicians, **Wayne Limber, Shig Horio, John Carr** and **Duane Truesdell** to join them from 6:30 to 7:30 A.M. at "Number Threes" (if breaking) and at "Ala Moana" any weekday. (We are a little baffled by the surfers' lingo.) These surf bums keep their boards in their offices and take wave breaks in their "backyard" instead of coffee breaks. . . .

### EDWARD T. SHIMOKAWA, M.D.
### 1905-1966

Dr. Edward Toshikazu Shimokawa was born in Lahaina, Maui, on March 11, 1905, the eldest son of Gihichi Shimokawa and Haru Inouye Shimokawa. He attended Kamehameha III School and went on to McKinley High School, from which he graduated in 1923. His college education was obtained from the University of Hawaii where he graduated in 1927. He received his M.D. from St. Louis University School of Medicine in June, 1931. His internship at St. Mary's Hospitals affiliated with the University Hospital in St. Louis, Missouri, was completed on July 1, 1932.

He started his formal practice of medicine in Lahaina in March, 1933, and was engaged in private practice in Lahaina until 1950, at which time he became associated as a plantation physician with the Pioneer Mill Company Hospital in Lahaina. In 1953, he became Superintendent of the hospital, which position he kept until the hospital closed in 1958. Dr. Shimokawa became in 1960 a partner in the Maui Medical Group, which he had helped form and with which he remained in practice until his death, in charge of their Lahaina office.

Dr. Shimokawa was an active member of the Lahaina Methodist Church. He belonged to the Maui County Medical Society, the Hawaii Medical Association, and the American Medical Association. He was a former Trustee of the Kula Hospital on Maui, and former President of the Maui County Medical Society.

He lived in Lahaina with his wife, Merle Okada Shimokawa, of Maui, and their six children, Diane, Edean, Edwin, Susan, Owen, and Brian, who survive him, as well as three brothers, Ralph T., Francis G., and John N., and one sister, (Hitoe), Mrs. Edward Miyahara.

An avid sports enthusiast, Dr. Shimokawa acted as team physician for the Lahainaluna High School for several years. Among his many hobbies was fishing, which he was able to enjoy in Lahaina. Of the many physicians in Hawaii who were born and raised in Lahaina, Dr. Shimokawa was the only one who chose to return to Lahaina to practice medicine, where, with his attentive, genuine interest in his patients, he endeared himself to the local population.

WILLIAM E. IACONETTI, M.D.

*Golfers:* In the merry merry month of May, it seems that everyone paced B flight at the Waialae. **Gil Freeman** started the ball rolling by pacing B flight in early May. He was followed by **Tommy Chang** who paced B flight and also won the Stableford. **Ted Tomita**, not to be outdone, was the next pacer, followed by **Toru Nishigaya.** The lone C flight pacer was **K. S. Tom** with 37. **Mac Mitsuda** and partner took team bestball. **Herbert Nam** shared top honors in the Korean Golf Club tournament at Pali with 83-13-70.

The Annual HMA Golf Tournament went off without a hitch, i.e., no thunderstorms or cloudbursts. This was evident from the scores. There were four ties for first place with 69's. The rankings from the coin flips were as follows: **Sam Yee** won the **O. D. Pinkerton** presidential trophy, and **Roy Tanone** won the silver plate and low gross honors. **Herbert Takaki** was third and **Yasuyuki Fukushima** fourth. Four others were tied with net 70's: **Toru Nishigaya, Joe Nishimoto, Kiku Kuramoto,** and **Chew Mung Lum.** At net 71's, **Gil Freeman** and **L. Q. Pang** tossed coins and at net 72's, **Peter Kim, Randy Nishijima,** and **Al Ishii** did their coin flips. They were followed by **Nobu Nakasone** with net 75 and **Ted Tomita** with net 76. Everyone agreed that the scores were more "legit" this year. . . .

*Tennis:* The 2nd Annual HMA Tennis Tournament directed by **Fred Gilbert** was blessed by a blistering sun after being threatened earlier by a Manoa thunderhead. The 30 participants gathered at the Iolani courts still rubbing their sleepy eyes at 7:30 A.M. There were muffled groans and sly grins as the participants drew their partners' names. In A flight, it soon became evident that the combo of towering **Ben Tom** and steady **Leabert Fernandez** was the team to beat as they trounced their opponents, including second place winners **Yutaka Yoshida** and **Cal Sia.** The touted team of **Hiro Tottori** and **Walton Shim** placed last, while third place was won by **Shig Horio** and **Hunky Chun.**

In B flight, perennial winner **Mort Berk** (aortic regurg and all) and **H. Yokoyama** ran a comfortable lead over second place winners, **Charley Ching** and **Fred Dodge.** There was some rumbling about improper seedings, so next year's chairman **Yutaka Yoshida** promises that **Charley Ching** and **Mort Berk** will be promoted to A flight.

## HMA Convention Highlights . . .

On opening day, hard-working **Bob P. C. Ho,** Chairman of the Scientific Program, cut a standout figure in red bow tie with immaculate white jacket and droned away at the sleepy 7:00 A.M. session. He introduced **Howard L. Polley** from Mayo Clinic, who gave a thumbnail sketch of connective tissue diseases, later disputed by **Edwin Fisher** from the University of Pittsburgh, who enlivened the program with a friendly barter of criticisms of the Polley concept of connective tissue diseases. Drawling **Walter Chang** introduced the afternoon speaker **Edward Boland** of the University of Southern California, who in a booming voice read his profound script, "Gout, Its Clinical Features and Management." We found that nothing triggers sleep better than a hypnotic lecture read against a background of slides in a darkened lecture hall. We woke up to UCLA's **Martin Blazina,** who gave an excellent instructive talk on "The Adolescent and His Knees." We were then "transported" by **Rev. Howard Clinebell's** desexed marriage-counselling lecture spiced by such wisecracks as "Marriage is a wonderful institution. No family should be without it" and "I am the boss in my family. My wife gave me permission to say that." . . . We listened with awe to **Maj. Gen. Byron Steger's** talk on "The Army Medical Service in Viet Nam." We wish to thank the Geigy Pharmaceutical Company for making this program possible, and congratulate **Bob Ho** for an excellent program pieced together. . . .

*continued page 56*

### GLENN NORIYUKI YANAGI, M.D.
### 1921-1966

Glenn Noriyuki Yanagi was born on December 20, 1921. After high school, he spent two years at the University of Hawaii before going to Columbia University. Upon receiving his Bachelor of Arts degree from Columbia, he worked for his Doctorate of Philosophy at Harvard University Graduate School, in the biological sciences. He did significant studies in parasitology, contributing several papers on the trypanosomes. His lifelong interest in the problems of cancer led him to seek a medical degree. In 1951, he received his Doctorate of Medicine from Harvard Medical School. His postgraduate medical education included training as a house officer at the Queen's Hospital. In August, 1953, he was licensed in Hawaii and embarked in general practice, meeting, among other things, head-on with the enigmatic challenges of cancer.

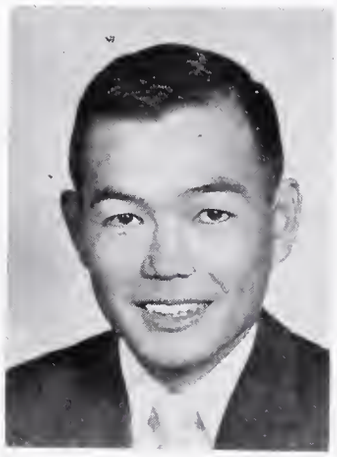
If there are suitable terms to characterize his career, the words tragedy and courage come to the fore. From his earliest years, he was afflicted with the painful, deforming manifestations of rheumatoid arthritis. By the time he was in his first year at the University of Hawaii, his entire spine was literally frozen, and many a schoolmate could recall, not without distress, the image of his stiff, wooden frame, slowly, laboriously, making its way about the campus. He worked hard at controlling his disease and pains so as to present no aspect of suffering to his friends and colleagues; this was true even during the severest exacerbations which visited him while in medical school. There was the tragedy of a marriage which ended in two weeks. It was obvious that his love was a deep one, and his hurt, a profound and abiding one. This episode was a factor in his return to Hawaii, and to a momentary loss of interest in research and all other facets of medicine. The most tragic event of all occurred in an automobile accident in 1958, wherein he suffered a transection of the cord and became permanently paralyzed from the waist down. To the amazement of all, he rebounded from this to reopen his practice, albeit in a wheelchair! Again, he saw and healed patients as best he could and planned experiments on cancer. His interest in good music, great literature, and the arts, in life in general, was renewed. But the human body could stand only so much, frail thing that it is. On February 27, 1966, it succumbed to the intercurrent infections and all the complications inherent in the paraplegic state, but not his spirit. Courage marked it to its core.

In Dr. Glenn N. Yanagi's passing away, the Hawaii Medical Association has suffered a deep loss. Surviving him are: his mother, Mrs. Yaeko Yanagi; three brothers, Harold Y., Walbert T., and Dr. Garret H. Yanagi; and a sister, Mrs. George T. Nakamura. The Hawaii Medical Association wishes to express its deepest sympathy to them.

NOBUYUKI NAKASONE, M.D.

HAWAII MEDICAL JOURNAL

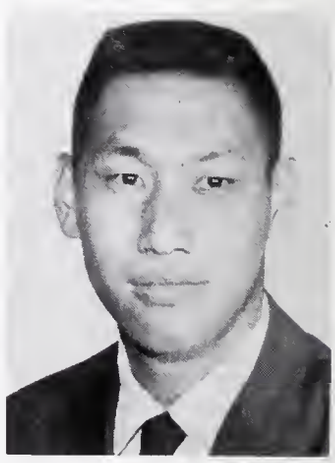
# New Members



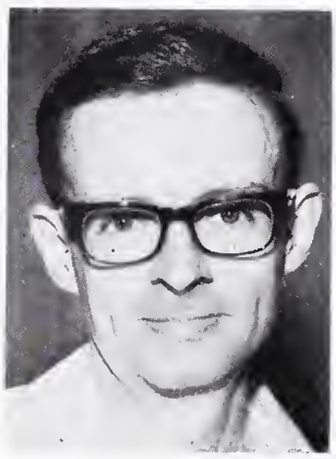
**Roy F. Kuboyama, M.D.**
1010 South King Street, Suite 104-105
Honolulu, Hawaii 96814
PEDIATRICS
University of Wisconsin—1960
Internship—The Queen's Hospital—1960-1961
Residency—Charity Hospital, New Orleans—1964-1966



**Edwin P. Gramlich, M.D.**
888 South King Street
Honolulu, Hawaii 96813
PSYCHIATRY
University of Oregon—1957
Internship—Oakland Naval Hospital—1957-1958
Residency—Camarillo State Hospital—1962-1965



**Raymond J. C. Wong, M.D.**
1507 South King Street, Room 305
Honolulu, Hawaii 96814
PEDIATRICS
Creighton University—1960
Internship—King's County Hospital, New York—1960-1961
Residency—St. Vincent's, New York—1961-1963



**James Harlock Johnston, M.D.**
1834 Nuuanu Avenue, Room 101
Honolulu, Hawaii 96814
OPHTHALMOLOGY
University of Michigan and University of Louisville—1959
Internship—The Queen's Hospital—1959-1960
Residency—The Queen's Hospital—Pathology—1960-1961
The Detroit Receiving Hospital—1961-1964
The Kresge Eye Institute—1961-1964

# County Society News

## Kauai

At the May 2 meeting correspondence from the HMA was reviewed. Dr. Brennecke, HMA Alternate Delegate, was advised that Dr. Kim, the regular delegate, would not be able to attend the annual meeting. A letter from HMSA advised the Society that Dr. Wade's term as a director would expire. The Society was asked if it proposed to submit names of its members to be considered for this position. It was moved not to submit any names to HMSA. The motion failed to carry. A second motion was made which noted that since there is no contract, the Society is under no obligation to submit names and HMSA is free to appoint individual physicians it feels are qualified to serve on its Board. The motion carried.

Dr. Kim asked for Society assistance in operating a utilization committee. It was voted that the Society develop a special committee or use its Board of Censors to act as a body to arbitrate any problems that may arise in connection with the utilization committees of any of the three hospitals.

It was voted to write the HMA and advise of the Society's willingness to assist in any proposed programs the Association may hold on Kauai in the future.

* * *

Dr. Wilbur Lummis was invited to the June 6 meeting to talk on PL 89-97. He explained the home health care program and noted the requirement that there be an ad-

*continued page 56*

● IMPORTANT! CONVENTION REGISTRATION FORMS ●

# AMA '66 LAS VEGAS

**POSTGRADUATE COURSES EXTRAORDINAIRES!**

The 20th AMA Clinical Convention in Las Vegas, November 27-30, will offer three important Postgraduate Courses on topics of vital interest to the practicing physician . . . Fluid and Electrolyte Balance, Obstetrics and Gynecology, and Cardiovascular Disease. Eminent specialists in their fields will participate in programs to be given in three half-day sessions in the Las Vegas Convention Center.

**Registration for each of these sessions is limited . . . be sure you don't miss out on the program of your choice by using the form below to register in advance.** Because of the space limitation, please include a $10 registration fee for each postgraduate course you select.

DETAILS OF THE SESSIONS:

**OBSTETRICS AND GYNECOLOGY**

Monday thru Wednesday, Nov. 28-30, 9 a.m.-12 noon
Course Director and Moderator:
Daniel G. Morton, M.D.
Professor and Chairman, Dept. OB-GYN
UCLA
Including 30-minute presentations on:
Management of Septic-Abortion
Intrauterine Transfusion for Erythroblastosis Fetalis
Hypertensive Disorders in Pregnancies
Human Sterilization: Indications, Legal Implications, Methods
Each presentation will be followed by a 10-min. discussion period.

**CARDIOVASCULAR DISEASE**

Monday thru Wednesday, Nov. 28-30, 2-5 p.m.
Course Director:
George C. Griffith, M.D.
Emeritus Professor of Medicine
University of Southern California, Los Angeles
Recent Advances in Operable Cardiovascular Disease
Pulmonary Embolism: Prevention, Recognition, Treatment
Regional Arteriosclerosis
Each half-day session will be followed by a 30-minute panel discussion by all participants.

**FLUID AND ELECTROLYTE BALANCE**

Monday thru Wednesday, Nov. 28-30, 9 a.m.-12 noon
Course Director:
Telfer B. Reynolds, M.D.
Professor of Medicine
University of Southern California School of Medicine
30-minute presentations on:
Basic Concepts in Fluid and Electrolyte Balance
Dehydration and Uremia
Hyponatremia
Hypokalemia and Hyperkalemia
Normal Acid-Base Balance
Acidosis and Alkalosis
Each morning's program will feature a 90-minute panel discussion.

**FOUR EXCEPTIONAL BREAKFAST ROUND TABLE DISCUSSIONS**

Tuesday, Nov. 29, 7-8:30 a.m.
1. "The Management of Metabolic Bone Diseases"
2. "Indication for Cardioversion"

Wednesday, Nov. 30, 7-8:30 a.m.
3. "The Problems and Potential of L.S.D."
4. "An Agonizing Reappraisal of Cancer Chemotherapy"

**The price of each breakfast will be $3.00. Indicate your choice on the coupon below and include payment.**

**FOR ADVANCE REGISTRATION OF PHYSICIANS**
(PLEASE PRINT)

Name_____
(Each Physician Must Register in His Own Name)

_____
Street

_____
City State Zip Code

I am a Member of the AMA thru the_____State Medical Association or in the following government service

_____

**ADVANCE REGISTRATION INFORMATION**

☐ General Registration *Only* (No Fee)

Just fill in the coupon above.
(This coupon must be returned before Nov. 14, 1966, to receive your Advance Registration Identification Card for Las Vegas. Your card will be sent to you on Nov. 17 unless you request an earlier mailing date.)

☐ **GENERAL REGISTRATION PLUS POSTGRADUATE COURSE REGISTRATION**

Fill in the coupon at the left and indicate your choice of course(s) below and return entire card.
(Cost of each course is $10.00, payable in advance.)

☐ Obstetrics and Gynecology
☐ Fluid and Electrolyte Balance
☐ Cardiovascular Disease

☐ **BREAKFAST ROUNDTABLE RESERVATIONS**
(Cost is $3.00 per plate, payable in advance.)
☐ "The Management of Metabolic Bone Diseases"
☐ "Indication for Cardioversion"
☐ "The Problems and Potential of L.S.D."
☐ "The Agonizing Reappraisal of Cancer Chemotherapy"

My remittance of $_____is enclosed.

PLEASE RETURN TO:
Circulation and Records Dept. 535 North Dearborn Street
American Medical Association Chicago, Illinois 60610

# JOIN THE SPECIAL HMA TOUR

***Leaving Honolulu November 26***

$260.00 a person includes three nights at the Stardust Hotel (double occupancy), round trip (first class) to Las Vegas via UAL, two breakfasts at Stardust, one dinner show at Stardust, two cocktail shows at Stardust, transportation to and from airport to hotel.

Kodak
TRADEMARK

# Diagnostic reliability




For diagnostic reliability you must have x-ray film that produces accurate, readable images time after time. With KODAK BLUE BRAND Medical X-ray Film, you get that kind of built-in uniformity of contrast and sensitivity. KODAK BLUE BRAND Film plus KODAK X-OMAT processing in KODAK X-OMAT Chemicals provide the complete system that assures radiographs of highest quality every time.

**Radiography Markets Division, EASTMAN KODAK COMPANY, Rochester, N.Y.**

# Enzyme Reaction



Our word 'enzyme' is derived from ζύμη—Greek for sourdough. In learning to bake, man learned the importance of acidity, time, temperature and technique... the same variables which control enzyme reactions in our laboratories today.

**Variables must be controlled** in prothrombin time testing, as in any enzyme assay. The system in which fibrinogen represents the substrate, thrombin the enzyme, is extremely sensitive to even minor aberrations. Relatively small changes in temperature or pH can add dangerous seconds to the prothrombin time.

**Diagnostic Plasma Warner-Chilcott monitors all variables** in both the normal and therapeutic range. Standardized to contain all clotting factors in optimal amounts, it dependably detects errors due to temperature, pH, reagents or contaminants. And it is the only control plasma available for citrated as well as oxalated samples. So, to avoid "half-baked" results, make...

**Diagnostic Plasma** Worner-Chilcott
your control in prothrombin time testing

GENERAL DIAGNOSTICS DIVISION
WARNER-CHILCOTT LABORATORIES MORRISTOWN, N.J.

GDJ-1276

# HAWAII TECHNOLOGISTS' BULLETIN

*Official Publication of the Hawaii Society of Medical Technologists*

*Editor:* STELLA YOSHIDA, U. S. Army Tripler Hospital

## *President's Report*

The thirty-fourth Annual Convention of the American Society of Medical Technologists was held on June 19-25, 1966, in the City of Los Angeles. For the first time, Hawaii was represented by four delegates, Edith Eckstein, Louise Wulff, Gertrude Ching, and yours truly. Having a couple of "old timers" with us certainly relieved much of the anxiety and apprehension of attending my first convention. To relax we attended the Dodger-Giant baseball game and watched Sandy Koufax win another game. We also visited Hollywood Park. Among the many friends who sent their aloha to the Med. Techs in Hawaii were Ruth Heinemann, Ellen Anderson, Lenna Lloyd, Elsbeth Mountien, Barbara Isabell, and Charlie Humes. These and many more have not forgotten our Hawaiian hospitality.

The House of Delegates initiated a new procedure to conduct its business meetings. All motions and resolutions were introduced at the first session and assigned to one of the five reference committees: (1) Future Plans and Policy, (2) Educational Activities (Louise Wulff was a member of this committee), (3) Public Information and Relationships, (4) Membership Services, (5) Resolutions and Miscellaneous. These reference committees held hearings to allow the membership to debate the issues. The findings and recommendations were then presented to the House for final action at the second session. In previous years, all the issues were debated on the House floor, a process which was time-consuming and tiring.

The recommendations of the Planning and Scope Committee were submitted as concepts to be adopted with the details to be worked out later. Some of the topics were the Scientific Assembly, Regional Concept, Board of Directors, Research and Educational Development, and ASCP.

The idea of the Scientific Assembly is to have the membership divided into fields of interest, with each section being responsible for setting up its own educational programs. All the programs would be open to all members. Eventually the chairman of each section could be part of the national convention program committee. The Regional Concept calls for dividing the states into eight regions and grouping them according to total membership. Each Region would elect a director who would serve on the Board of Directors and provide liaison between ASMT and the constituent societies. With the addition of eight Regional Directors the Board would total fifteen. The Committee further recommended that the terms of office of the Board be staggered to allow for only one-third of the officers to be elected each year. Thereafter, the terms for Recording Secretary, Treasurer, Members-at-Large, and the Regional Directors would be three years. The President-elect, President, and Past President would have terms of one year. The result should be better continuity in the operation of ASMT.

Planning and Scope also recommended a joint meeting of an equal number of officers and representatives from both ASCP and ASMT to discuss issues relating to certification and education of medical laboratory personnel, the discussions to be moderated by an impartial outsider. Some of the topics to be covered would be: equal representation of both organizations on all boards, establishment of a means of communication between ASCP and ASMT to avoid misunderstandings of policies and overlapping of activities, unfulfilled requests of ASMT, accreditation of schools, and the discontinuation of the ASCP-ASMT Joint Commission on Continuing Education in Medical Technology. There is some feeling within ASMT for an eventual break with ASCP. The outcome of this meeting might give us a clue as to our future connection with ASCP. Remember, all of these recommendations were merely stated as concepts; the final details will be formulated in the next few years.

Of the eighteen amendments submitted by the Constitution and Bylaws Committee the first 16 were adopted. Nos. 17 and 18, dealing with membership categories and qualifications, a grandfather clause, and student qualifications, were referred back to committee. The majority of the members felt that the minimum qualification for active membership should be a baccalaureate degree.

Judging by the promptness with which we received our renewal notices, right after the House of Delegates adjourned, the dues increase was a foregone conclusion. There is no doubt that the increase is needed. First of all, we have a deficit of $12,500 to clear off the books. We need money to implement the suggestions of the Planning and Scope Committee. If we are to progress in our goal of a truly professional organization, we need money to reorganize the Executive Office, expand our continuing educational program, and conduct many more activities. Do we stand still or move ahead? We need every eligible Med. Tech to help ASMT progress and mature professionally. ASMT is working for you. Please give it your financial support.

The revision of the bylaws will be accomplished by a special committee composed of two members from each constituent society. This committee will meet immediately following the 1967 annual convention. Since our President-elect, Gilbert Gima, will be attending the Convention in Florida, his name will be submitted as one of our representatives. If anyone is planning to attend the 1967 Convention, please let me know.

Las Vegas won out over New York as our 1971 convention site. As was mentioned, next year it will be in Florida, Texas in 1968, Philadelphia in 1969, and Detroit in 1970. Many of you should give some thought to taking your vacations and spending some time at the Convention. This way you will be helping HSMT as a representative and helping yourself by taking in the many educational programs offered by ASMT. You can also deduct the expenses on your income tax. I hope in the years to come that HSMT will continue to have larger delegations attending the national conventions.

ELAINE (TINY) CHANG, MT (ASCP),
*President*

## *Educational Reference Committee*

The activities of the Educational Reference Committee at the 34th Annual Convention naturally held more interest for me than the other committees but actually, the motions brought before this committee were of broad interest and not confined to formal educational problems alone so the discussion meetings attracted many technologists not engaged in teaching.

The resolutions considered covered awards, CLA training, the CLA board and examinations, hematology, nuclear medical technologists, scholarships, registry problems, and the ASMT Education and Research Fund.

At the open session (following a brief preliminary committee meeting), any interested delegate was encouraged to speak out—and they did! Attendance at this session ranged from ten to a hundred people. They came and went as other meetings they were committed to were scheduled.

In making final recommendations, the committee was instructed to consider these floor discussions and to take a vote on issues that were controversial. It was emphasized that the committee was not bound by expressions from the open meeting, however. In the session of our committee when we worked up final recommendations to be presented to the House of Delegates, we used the minutes of the open session as guidelines and did follow its suggestions generally. At the House of Delegates meeting our recommendations were usually adopted without discussion except for the more controversial issues.

Any state society may make a resolution but some states are particularly active and the Massachusetts and California societies were very busy in this area last year. Massachusetts submitted four resolutions, all concerned with registry requirements or the wording of these requirements, or both. While the reference committee felt that the registry might need to clarify some statements, it did seem as if Massachusetts was being a little too picky with the registry and not quite careful enough with its own statements. Especially when they said "There are very few colleges or universities offering an undergraduate degree in microbiology"!

While Massachusetts engaged in detail, California made sweeping and emotional statements such as this one from the California Protest Resolution: "Whereas, the present Government is bent on lowering any and all standards to allow the unqualified to be hired. . . ." Such statements really lent spice to the sessions, for the discussions they engendered were lively, to say the least.

The resolutions and the action taken on them is a matter of record and need not be repeated here. From the House actions, the open discussions, and the reference committee meetings themselves, it can be seen that Medical Technologists generally are deeply concerned with trends in several areas. One is the matter of CLA training and of other personnel whose training needs are less than those of a registered technologist, such as histology technicians. The fear that laboratory assistants will outnumber medical technologists, who will then lose control of medical technology, is widespread, but I couldn't see that anything is being done on a national scale except to protest.

A second area of concern is the slowness with which medical technologists are progressing to autonomy, i.e. setting their own professional standards and accrediting their own schools. California is a leader in this struggle with its strong licensure program. Whether or not it is the best way is controversial, but it is one way to come of age professionally.

These sessions made clear the need for resolutions that are well expressed, reflect mature consideration of national needs, and are specific enough to be meaningful in a practical way. Wild, heroic generalities maketh a big noise and getteth us nowhere. ■

LOUISE WULFF, M.T. (ASCP)


HAWAII'S ELECTROMEDICAL EQUIPMENT CENTER

Recognized Quality Equipment and On-the-Spot Service with Factory-Trained Personnel and Locally-Stocked Parts

BURDICK
ELECTROMEDICAL EQUIPMENT



**Electrocardiograph**

**EK-IV** — Dual speed Electrocardiograph — available stand makes it perfect for either office or hospital use.

**PC-100 HEART SOUND PREAMP** — Permanently records heart sounds without elaborate and expensive equipment.

**FM-1 PHOTOMOTOGRAPH** — Simplest and fastest method of diagnosing thyroid dysfunction.



**Monitoring**

**CS/50 THREE-CHANNEL MONITOR**—Monitors three essential phenomena — electrocardiogram, electroencephalogram and pulse rate and rhythm.



**Therapy**

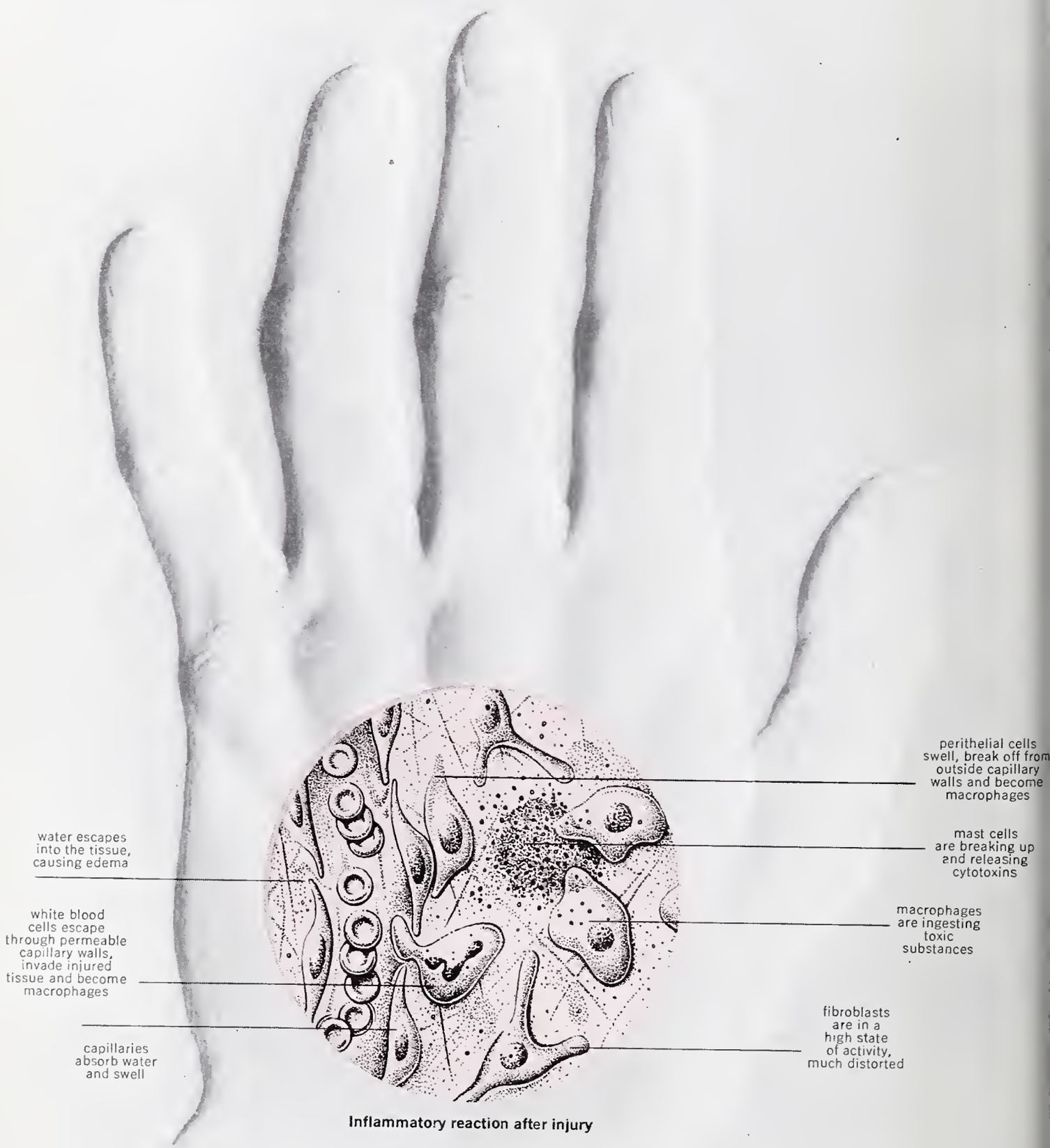
**MW-200 MICROWAVE DIATHERMY** — Produces temperature increases in muscle tissue up to 7.81° F. at a depth of two inches by means of high-frequency radiations.

**MF/490 SHORT WAVE DIATHERMY** — Designed for use with all types of diathermy electrodes.

SERVING HAWAII GASPRO LTD. OVER 50 YEARS

X-RAY DEPARTMENT
Phone 813-311
2305 Dillingham Boulevard, Honolulu
BRANCHES: Hawaii, Maui, and Kauai

# Cinemicrography* of living tissue shows that Synalar works at the cellular level to stop the inflammatory chain reaction




**Inflammatory reaction after injury**

*A New View of Corticosteriod Action in Inflammatory Dermatoses
A 16 mm. film utilizing time-phase cinemicrographic techniques. Available for showing on request to Syntex Laboratories.

In contact dermatitis

# Synalar®

(fluocinolone acetonide)

stabilizes cell and capillary walls
protects against the chemical impact of cytotoxins

interrupts the chain reaction of destructive changes at the cellular level

permits inactivation, absorption and transportation of toxins away from the injured area by natural processes...edema is absorbed and cells return to normal size, shape, and activity

**In inflammatory dermatoses** choose a steroid synthesized specifically for topical use. Synalar (fluocinolone acetonide) provides therapeutic results often comparable to those of systemic and intralesional corticosteroids with fewer hazards.[1-3]

**when complicated by infection**

## neo-synalar®

(fluocinolone acetonide-neomycin sulfate cream)

**For initiation of therapy:** Cream 0.025%, 5 and 15 Gm. tubes, 425 Gm. jars; **for emollient effect:** Ointment 0.025%, 15 Gm. tubes; **for maintenance therapy:** Cream 0.01%, 15 Gm. tubes, 45 Gm. tubes, 120 Gm. jars; **for intertriginous or hairy sites:** Solution 0.01%, 20 cc. and 60 cc. plastic squeeze bottles; **for infected inflammatory dermatoses:** Neo-Synalar® Cream (0.025% fluocinolone acetonide, neomycin sulfate, equivalent to 0.35% neomycin base), 5 and 15 Gm. tubes.

**Contraindications:** Tuberculous, fungal, and most viral lesions of the skin, (including herpes simplex, vaccinia, and varicella). Not for ophthalmic use. Contraindicated in individuals with a history of hypersensitivity to any of its components. **Precautions:** Synalar preparations are virtually nonsensitizing and nonirritating. However, the solution may produce burning or stinging when applied to denuded or fissured areas. In some patients with dry lesions, the solution may increase dryness, scaling or itching. The neomycin in Neo-Synalar Cream rarely produces allergic reactions. Prolonged use of any antibiotic may result in overgrowth of nonsusceptible organisms; if this occurs, appropriate therapy should be instituted. Where severe local infection or systemic infection exists, the use of systemic antibiotics should be considered, based on susceptibility testing. While topical steroids have not been reported to have an adverse effect on pregnancy, the safety of their use on pregnant females has not absolutely been established. Therefore, they should not be used extensively on pregnant patients, in large amounts, or for prolonged periods of time. **Side Effects:** Side effects are not ordinarily encountered with topically applied corticosteroids. As with all drugs, however, a few patients may react unfavorably to Synalar under certain conditions.

**References:** 1. Kanee, B.: Canad Med Ass J 88:999 (May 18) 1963. 2. Scholtz, J. R.: Calf Med 95:224 (Oct.) 1961. 3. Jansen, G. T., Dillaha, C. J., and Honeycutt, W. M.: Arch Derm 92:283 (Sept.) 1965.

fluocinolone acetonide—an original steroid from

SYNTEX LABORATORIES INC., PALO ALTO, CALIF.

## *County Society News* *continued from 48*

visory committee. This committee will consist of Drs. Miyashiro and Kim, and Mesdames Hiyane and Haas. Dr. Lummis also reported on the role of the hospital's Utilization Review Committee.

It was voted to ask the Hawaii Heart Association to have Dr. Luke address the Society on Cardiopulmonary Resuscitation. The proposal to have a program on rheumatic fever was tabled pending more information. It was voted to endorse the TB and Health Facilities program to establish a loan closet for patients with asthma and other chronic pulmonary conditions.

Dr. James Warner was elected Secretary-Treasurer to complete the term of Dr. Morris who is transfering to the mainland. It was voted to pay for the travel costs of a representative to attend a Foundation meeting in Honolulu. ■

## *Notes and News* *continued from 47*

### Professional Moves

Medical partnerships and associations are like common law marriages, i.e. they are not as binding and have a high separation rate. We note that **Bob Peyton** has "disassociated" and has joined the Medical Group and **Fred Dodge** has left Nuuanu for Aiea and solo practice. A neurological surgeon, **Juris Bergmanis,** has also joined the Medical Group.

Political appointments are equally tenuous. Our good Mayor persuaded **David Katsuki,** City-County physician since 1955, to leave and has appointed **Ray Hiroshige** in his place. David, it seems, "is hurt and feels that he was unjustly treated after all his years in public health service."

### Members Speak Up

In May, retiring President, **O. D. Pinkerton,** in his farewell address at the HMA annual meeting got in his licks on Medicare and LBJ. He felt that Medicare has the capacity for great good or greater evil. He said, "The evil I refer to is the assumption by the Federal government of powers that do not belong to it. . . . We know who the architect of Medicare was, and how many years of relentless effort it required . . . What other 'goodies' does this person have up his sleeve and how many others are working just as ardently and devotedly to creating the complete socialist state?" Later in June, he was more reticent as a panel speaker on Medicare at Farrington High School. He said, "The fact that a form of socialized medicine has become law doesn't cause us to back away and refuse to try to implement the law." He reassured the public that the medical profession will support the implementation of Medicare. "Hopefully, in this way, we can keep it from becoming a generalized socialized medicine program which I believe it is destined to become."

We were delighted that PTA president **Felix Lafferty** raised a virtual hornet's nest. He wrote the Board of Education that the new Aina Haina School principal's appointment has "loosened a virtual torrent of protest from parents in the district" and urged the appointment be reconsidered. Besides the comments from other Board members, we were pleased with **Dick Ando's** tactful approach as he said, "In fairness to the principal named and in view of the criticisms, the Board should undertake an examination to see whether the criticism was valid or unjust." We are happy to see physicians active in school affairs, and encourage their more active participation toward improving the quality of DPI teachers.

We read **Jim Cherry's** letter to the editor which compares the situation in Viet Nam to that of Sudetenland.

*continued page 60*

**MEDICAL PLACEMENT BUREAU**
**and**
**NURSES' REGISTRY**

24 HOUR SERVICE

**LET US SERVE YOU IN YOUR NEED**

Nurses, Staff and Office
Nurses, Private Duty
Nurses, Supervisors
Practical Nurses
Nurses, Aide
Dental Assistants
Physical Therapists
X-Ray Technicians
Laboratory Technicians
Medical Stenographers
Medical Clerks
Receptionists
Male Nurses
Bookkeepers
Home Companions

Frieda M. Beezley, R.N., *Director*
Patsy Harrison, *Secretary*

**1473 South King St.** **991-237**

CONSIDERING
CONTACT LENSES?

*Here's Good News!*

Newly perfected Micro thin lenses now provide:

- Shorter fitting time
- Greater comfort
- Reduced period of adjustment to lenses

We continue to offer highest quality and finest service for all your optical requirements.

GUILD OPTICIANS **OPTICAL DISPENSERS**
**of Hawaii, Inc.**

*Additional location at:*

**1133 BISHOP ST.** **576-570**
**312 ALA MOANA BLDG.** **976-925**

# Read now...




# save on taxes later!

If you are concerned about your family's financial future — how best to conserve money you are making now for their future use — you should read "Taxes and the Professional Man."

Written especially for professional men, it explains important aspects of Federal estate and gift taxes. How they may be minimized by sound planning. How trusts may serve your purposes. How the professional man who works for a corporation or institution should plan. Examples are included.

For a copy of "Taxes and the Professional Man," just write or call:

60 ANNIVERSARY 1906 1966

**BISHOP TRUST COMPANY**

*Trust Services Exclusively*

BISHOP AND KING STREETS · PHONE 563-771 ■

# new




## a new formulation that relieves pain in tension headache and neuralgia

Dialog is a combination of 15 mg allobarbital and 300 mg acetaminophen. Allobarbital, a proven barbiturate, provides desirable sedation in patients experiencing pain and discomfort. Acetaminophen is a nonsalicylate analgesic-antipyretic, well tolerated and useful in a wide range of mildly painful and febrile conditions.

Dialog is well tolerated, even by those sensitive to aspirin. It is nonirritating to the gastrointestinal tract and, in recommended dosage, has no adverse effects on the kidneys.

- Raises the pain threshold
- Suppresses the pain-producing mechanism
- Reduces emotional tension

2/3449 MK-3




# Dialog™

## (allobarbital and acetaminophen CIBA)

**Indications:** For relief of pain and discomfort of simple headache; neuralgia, myalgia, and musculoskeletal pain; dysmenorrhea; bursitis; sinusitis; fibrositis. Also indicated to reduce fever and to relieve discomfort due to respiratory infections, influenza, and other febrile conditions.

**Contraindication:** Not recommended during pregnancy.

**Caution:** May be habit-forming. Do not use in patients sensitive to barbiturates or in those with moderate to severe hepatic disease.

**Side Effects:** Nausea, transitory dizziness, rash. Overdosage of allobarbital produces symptoms typical of acute barbiturate excess.

**Dosage:** *Adults:* 1 or 2 tablets every 4 hours. Not to exceed 8 tablets in 24 hours. *Children 6 to 12:* ½ to 1 tablet every 4 hours. Not to exceed 4 tablets in 24 hours.

**Supplied:** *Tablets* (white, scored), each containing 15 mg allobarbital and 300 mg acetaminophen; units of 3 bottles of 30.

**For your convenience—prescription-size bottle of 30.**

CIBA Pharmaceutical Company, Summit, N.J.

CIBA

## *Notes and News* *continued from 56*

(For those not familiar with WW II history, Sudetenland was where historians feel Hitler's expansionist activities could have been easily restrained, but pacifists and isolationists opposed positive action.) Jim predicts, "If we do not stand in Viet Nam today and prevent Southeast Asia from being taken, we will stand on our own shores and combat the Communist hordes."

**M. H. Lichter** questions the propriety of a Senator's accepting per diem allowance to attend a funeral of his own fellow statesman. He says in magnificent prose, "In this tragic final hour, does one come to bury or to praise Caesar; or does one desecrate the dignity of this solemn occasion by justifying a funeral as a reimbursable function and thus a state's responsibility?" Sounds familiar, wot?

We noticed this short announcement: **"Dr. Cyrus Loo** will give a demonstration of handwriting analysis at the Christian Business and Professional Women's Council dinner. . . ." It prompts us to comment that physicians are a rare breed with mystic talents . . . Anyone also qualified in palm reading?

Medicine's self-appointed Viet Cong spokesman and medical society nonmember **Willis Butler** feels that LBJ chose to bomb Hanoi and Haiphong recently to discourage two separate peace missions which were en route to Hanoi. He feels that LBJ's goal "is total military victory, permanent Southeast Asia bases and U.S. domination, regardless of cost." This raised another storm of protest from the public . . .

Outspoken advocate of legal abortions **Howard Liljestrand** discussed "Pregnancy Control and the Population Explosion" at a luncheon of The League of Women Voters of Honolulu in June. Commenting more recently on California's Episcopal Bishop James Pike's statement advocating that California physicians disobey state laws which forbid abortions in cases involving German measles or mental stress of mothers, Howard commented "Doctors here are already doing what Bishop Pike recommends. It's an unofficial attitude in view of the way the law reads. But it's an attitude that has not been fought and no one's making any waves." Quaker **Masato Hasegawa** was more conservative. He said, "Doctors with good moral and ethical backgrounds won't buy that idea of 'civil disobedience.' They must abide by the law." Catholic **John Felix,** if he were here, might fumingly express yet another view. It certainly is interesting how our religious, rather than our medical backgrounds, tone our feelings about abortions. See **Bill Bergin's** article in our next issue.

## Elected, Appointed, and Honored

We congratulate **Herbie Chinn,** genial father of six children, for being selected Medicine's Father of the Year. We cannot think of anyone more qualified. His one-word summary of life with a demanding practice and his good-sized family—"hectic." We sympathize. . . .

Amiable **Tetsui Watanabe** was installed as President of the Hawaii Radiological Society and **Robert Edland** elected Vice-president. Also elected were **Don Ikeda** as Secretary-Treasurer and **Grover Liese** as Councilor.

We read that **Kenneth Haling** of Wailuku was appointed Coroner's Physician for Maui. The County Attorney was pleased that Haling's offer was "very reasonable." Physicians on Maui, it seems, are being categorized as either "reasonable" or "unreasonable."

Personable **Unoji Goto,** who grew up with the original open heart team, was elected the new President of the Hawaii Heart Association. **William Sage** is President-elect. Versatile **Paul Gebauer** was cited for his "interest and ingenuity" which helped facilitate the first open heart surgery here. We recall the heat exchanger he developed for a commercial disc oxygenator, which is

*continued page 64*




NEW 1967 CADILLACS SCHEDULED TO GO ON DISPLAY SEPTEMBER 29, 1966

See them at SCHUMAN'S
1234 South Beretania Street

# Carnation
EVAPORATED MILK



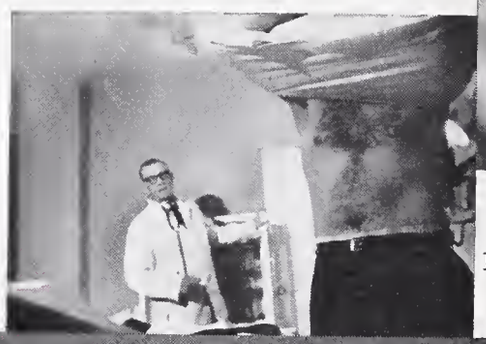

1965
Carnation Healthy Baby Contest
$1,000 1st prize winner,
Laurie Anne Medeiros
of Honolulu, Hawaii

## HAWAII'S HEALTHY BABY MILK...

***1st CHOICE FOR INFANT FEEDING...***
***No. 1 in the Islands for generations,***
***...available everywhere in Hawaii***

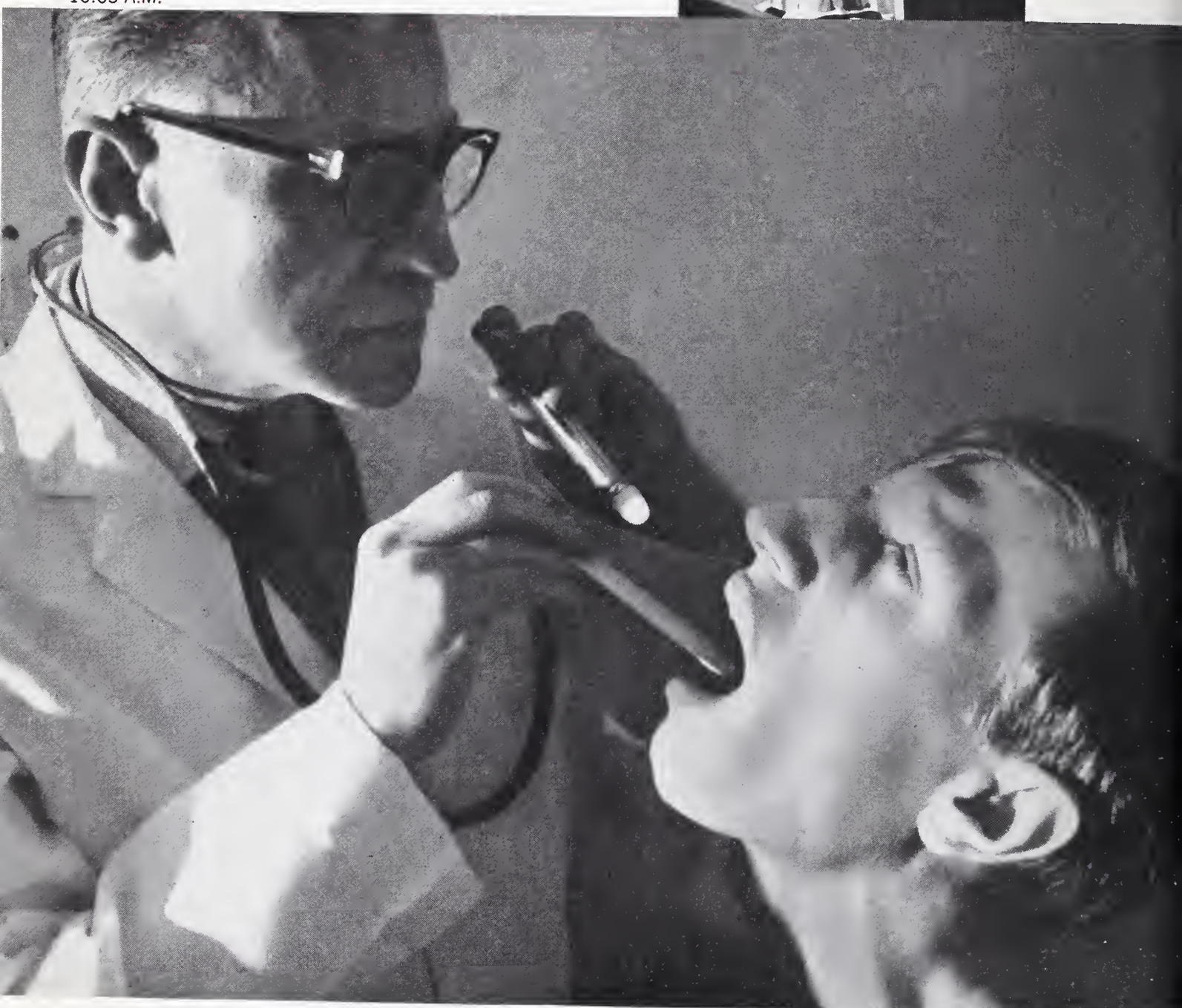
*"from Contented Cows"*

# This is the new, everyday penicillin for common bacterial respiratory infections...



10:38 A.M.

10:05 A.M.







10:42 A.M.

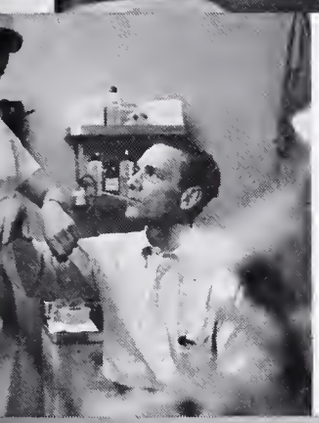
# ...the only low-cost antibiotic bactericidal against all common Gram-positive cocci



11:00 A.M.



11:20 A.M.



11:47 A.M.



12:01 P.M.

## Clinical success

Tegopen (sodium cloxacillin monohydrate) assures you a high degree of clinical success against respiratory infections. A recent comprehensive analysis of office patients administered the drug proves the point: *96% of 259 bacterial respiratory infections treated were cured or improved.*[1]

## Kills all common respiratory Gram-positive cocci

In contrast to the Gram-positive spectrum of penicillins G and V, Tegopen (sodium cloxacillin monohydrate) destroys strep, pneumo and virtually *all* staphylococci.

## Bactericidal in action

Tegopen (sodium cloxacillin monohydrate) is always bactericidal, killing the offending organism. Erythromycin[2] and triacetyloleandomycin[3] are essentially bacteriostatic agents which merely suppress bacterial growth.

## Minimal side effects

There is little likelihood of dose-related toxicity with Tegopen (sodium cloxacillin monohydrate).

## Low in cost

Even with all of its extra advantages, Tegopen (sodium cloxacillin monohydrate) is priced comparably to penicillins G and V, and 33% less than either erythromycin or triacetyloleandomycin.

BRISTOL THERAPEUTIC SUMMARY: For complete information, consult Official Package Circular. *Indications:* Infections due to streptococci, pneumococci and staphylococci, particularly penicillin G-resistant strains of the latter. *Contraindications:* A history of severe allergic reactions to penicillins. *Precautions:* Typical penicillin-allergic reactions may occur, particularly in hypersensitive persons. Mycotic or bacterial infections may occur. Safety for use in pregnancy is not established. Assess renal, hematopoietic and hepatic function periodically during long-term therapy. *Adverse Reactions:* Nausea, epigastric discomfort, flatulence, diarrhea, eosinophilia, and allergic manifestations. Moderate SGOT elevations have been noted. *Usual Dosage:* Adults: 250 mg. *q.* 6 *h.* Children: 50 mg./Kg./day. Children weighing more than 20 Kg. should be given the adult dose. Treat beta-hemolytic streptococcal infections for at least 10 days. Administer 1 to 2 hours before meals. *References:* 1. Data on file at Bristol Laboratories. 2. Geraci, J.E. (Panel Discussion, M. Finland, Moderator): Antibiot. Ann. 1958–59: 1051, 1959. 3. Thompson, W.T., Jr.: South. M. J. *56*:844 (Aug.) 1963.

BRISTOL LABORATORIES
Division of Bristol-Myers Co., Syracuse, New York

**IN TONSILLITIS · PHARYNGITIS · OTITIS MEDIA · SINUSITIS · BRONCHITIS · PNEUMONITIS**

1:15 P.M.

# new TegoPen®

SODIUM CLOXACILLIN MONOHYDRATE




The Royal Lahaina Hotel
KAANAPALI BEACH, MAUI
Your own private paradise . . . one of the loveliest resorts in the world. Wonderfully spacious cottages, each with its own lanai, overlook the green velvet fairways of the championship golf course and the white sandy beaches of the blue Pacific. A golfer's dream . . . a dreamer's holiday. Emphasis is on informality and superb dining.
Come to Maui soon. Come to the Royal Lahaina, your own private paradise by the sea.
ISLAND HOLIDAYS 2171 KALAKAUA AVE., HONOLULU
TELEPHONE: 931-111

## *Notes and News* *continued from 60*

being widely used. **Mort Berk** received a distinguished service award for his many contributions past and present to the Association and the community, and **George Henry** was awarded a service recognition award for his work as Chairman of the Research committee.

Our Health Fair won this year's Oahu Health Council annual award for the greatest single contribution to health in Hawaii. Fair Chairman **John Stephenson** received the plaque in ceremonies at the Mabel Smyth Auditorium and HMA president **Ted Tomita** described the Fair as representing "ungrudging cooperation of literally hundreds of organizations and individuals." Well said, for without their cooperation, the Fair would never have been as successful. . . .

Spartan **George Mills** never ceases to amaze us. Besides practicing full time, and being involved in innumerable community and medical organizations of import, he has added yet another duty to his 48-hour day by being named medical consultant for the AFL-CIO Hotel & Restaurant Worker's Health and Welfare trust fund. We cannot think of anyone more suited for the Lieutenant governorship!

**Francis K. Won** was recently elected president of the Hawaii Chapter of the Creighton Alumni Assn. and **Walter S. Char**, Secretary.

## Travellers and Social News

A pale, retiring **Arthur Wong** was carried through his wedding ceremony by best man **Clifford Chang.** The trusty ushers, **Robert Lee, Winfred Lee, Coolidge Wakai, Allan Leong,** and even auxiliary ushers **Charley Ching** and **Walter Chang** were on continuous alert for any signs of vascular collapse and ready to administer resuscitative measures when needed. Fortunately the bride was an attractive, demure tower of strength, who kept Arthur's choke chain tight enough to prevent escape. The crowded reception at the Village was an hour late, but this merely served to whet the appetites of the guests. After course number six, **Richard Chang** in flawless English and **Hing Biu Luke** in equally flawless Jackson School Chinese entertained the guests with the necessary proprieties. We vaguely remember three more courses after the speeches, but more conspicuous in our memories was the empty bottle of VAT 69 as we floundered out to breathe in the refreshing Waikiki air.

The **Patrick Coeketts** of Lihue celebrated their silver wedding anniversary by entertaining over 150 guests at the Wailua Country Club. The **Ralph Clowards** held a cocktail party for daughter Kathleen and husband. Attending were an array of doctors viz the **Rodney Wests, Pat Burgesses, Fred Gileses, Francis Nanees, Harold Johnsons, Lyle Phillipses** and **Marquis Stevenses** . . . Sounds more like a medical convention. More recently we saw a photograph of Ralph, his familiar naked pate decked with a beatle type hair-do and tooting "Alexander's Ragtime Band" on a red-hot clarinet at a Ruger Theatre birthday party.

In February, pediatricians **Joseph Oren** and **Alex Roth** attended the UCLA Medical School course on latest treatment methods of cystic fibrosis. The trip was sponsored by the Hawaii Chapter of the National Cystic Fibrosis Research Foundation . . . All we need now would be more cases. Studious **Ralph Beddow** spent his June vacation attending the Harvard Graduate School of Medicine's course on internal medicine at the Massachusetts General Hospital. **Dick Ando** and four other State Board of Education members attended the National School Boards Association meeting in Minneapolis.

## Doctors In Print

We congratulate the following for their contributions to medical literature . . . **Richard K. C. Lee** *et al,* "The

*continued page 68*



BLEMISHES?
COVERMARK conceals all skin discolorations . . . birthmarks, brown & white patches, broken veins, tattoos, burns, scars, on any part of the body. COVERMARK is also unexcelled as an overall makeup . . . will not rub or flake off. Waterproof and Sunproof.

Lydia O'Leary
OF HAWAII
ALA MOANA CENTER—STREET LEVEL
PHONE 993-288

ONLY 20 MINUTES FROM
DOWNTOWN HONOLULU . . .

# KAHANAOLA

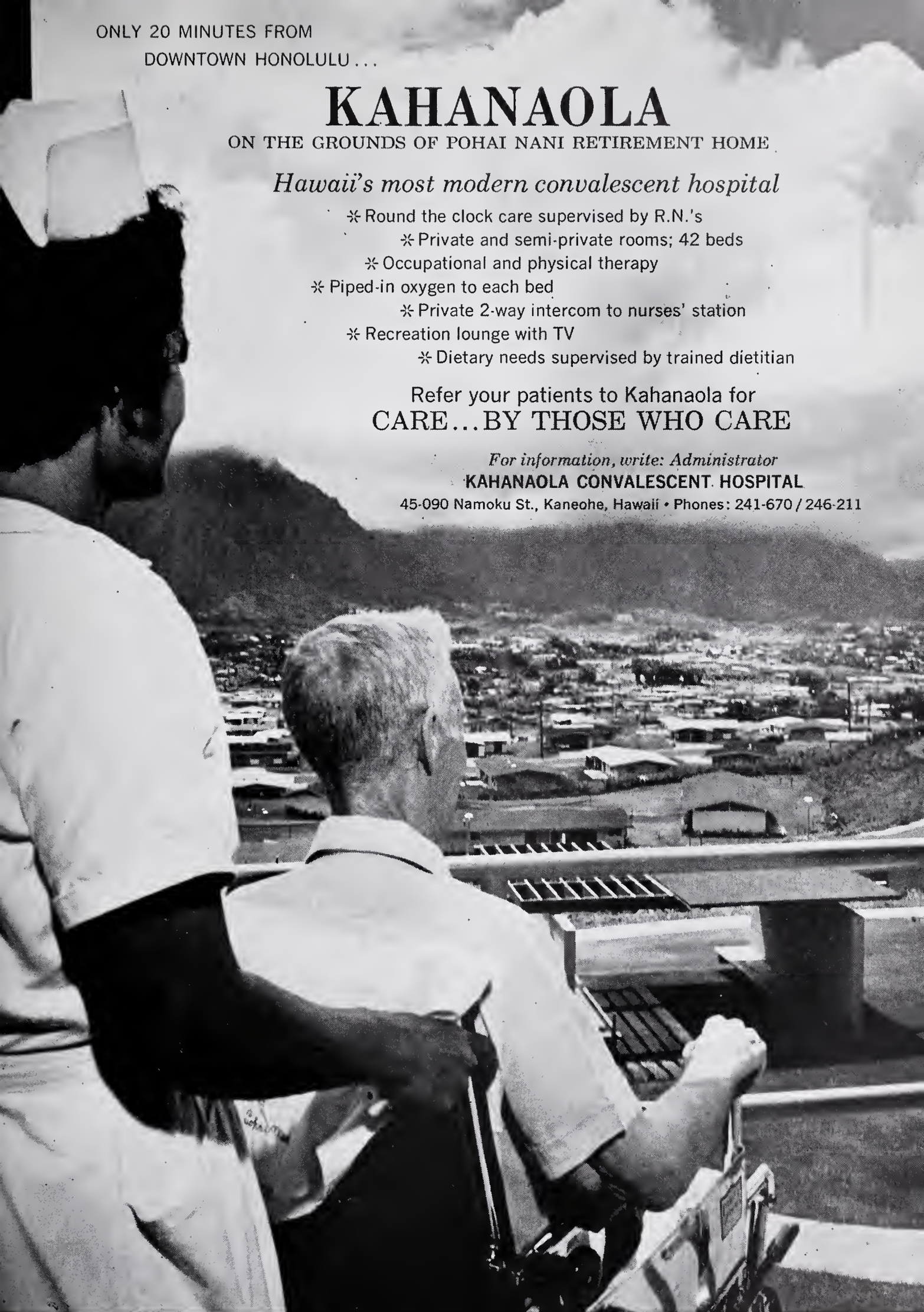
ON THE GROUNDS OF POHAI NANI RETIREMENT HOME

*Hawaii's most modern convalescent hospital*

- ✲ Round the clock care supervised by R.N.'s
- ✲ Private and semi-private rooms; 42 beds
- ✲ Occupational and physical therapy
- ✲ Piped-in oxygen to each bed
- ✲ Private 2-way intercom to nurses' station
- ✲ Recreation lounge with TV
- ✲ Dietary needs supervised by trained dietitian

Refer your patients to Kahanaola for
CARE . . . BY THOSE WHO CARE

*For information, write: Administrator*
**KAHANAOLA CONVALESCENT HOSPITAL**
45-090 Namoku St., Kaneohe, Hawaii • Phones: 241-670 / 246-211



**ENDORSED BY:** American Hospital Assoc. / Hawaii State Nursing Home Assoc. / Hospital Assoc. of Hawaii
American Nursing Home Assoc.

# in diarrhea

LOMOTIL® Tablets / Liquid

Each tablet and each 5 cc. of liquid contains:
diphenoxylate hydrochloride . . . . 2.5 mg.
(Warning: May be habit forming)
atropine sulfate . . . . . 0.025 mg.



# is a corker

**Effectiveness:** Lomotil possesses a unique degree of effectiveness in both acute and chronic diarrhea.

**Convenience:** Lomotil is supplied as small, easily carried, easily swallowed tablets and as a pleasant, fruit-flavored liquid.

**Versatility:** The therapeutic efficiency, safety and convenience of Lomotil may be used to advantage alone or as adjunctive therapy in diarrhea associated with:

- **Ulcerative colitis**
- **Acute infections**
- **Irritable bowel**
- **Regional enteritis**
- **Drug therapy**
- **Food Poisoning**
- **Functional hypermotility**
- **Malabsorption syndrome**
- **Ileostomy**
- **Gastroenteritis and colitis**

**Dosage:** For full therapeutic effect—Rx full therapeutic dosage. The recommended initial daily dosages, given in divided doses, until diarrhea is controlled, are:

**Children:** 3 to 6 months — 3 mg. (½ tsp.* t.i.d.)
6 to 12 months — 4 mg. (½ tsp. q.i.d.)
1 to 2 years — 5 mg. (½ tsp. 5 times daily)
2 to 5 years — 6 mg. (1 tsp. t.i.d.)
5 to 8 years — 8 mg. (1 tsp. q.i.d.)
8 to 12 years —10 mg. (1 tsp. 5 times daily)

**Adults:** 20 mg. (2 tsp. 5 times daily or 2 tablets 4 times daily)

*Based on 4 cc. per teaspoonful.

Maintenance dosage may be as low as one-fourth the therapeutic dose.

**Precautions:** Lomotil, brand of diphenoxylate hydrochloride with atropine sulfate, is a Federally exempt narcotic preparation of very low addictive potential. Recommended dosages should not be exceeded. Lomotil should be used with caution in patients with impaired liver function and in patients taking addicting drugs or barbiturates. The subtherapeutic amount of atropine is added to discourage deliberate overdosage.

**Side Effects:** Side effects are relatively uncommon but among those reported are gastrointestinal irritation, sedation, dizziness, cutaneous manifestations, restlessness, insomnia, numbness of extremities, headache, blurring of vision, swelling of the gums, euphoria, depression and general malaise.

SEARLE *Research in the Service of Medicine*

## *Notes and News* *continued from 64*

Center for Cultural & Technical Interchange Between East & West and Its Current Public Health Programs" *American Journal of Public Health,* April 1966; **J. E. Strode,** "Acute Cholecystitis as a Complication following Surgery unrelated to the Biliary Tract" *Surgery,* February 1966; and **Jerome Kern** and **Leon Rosen** "Identification of Enteroviruses by Hemagglutination Inhibition" *Journal of Bacteriology,* May 1966.

## Lederle Symposium

We are again grateful to the Lederle people for the combination of good lunches, fine stimulating drinks, and a trio of excellent speakers, but alas, all on a perfectly beautiful July Sunday. We congratulate **Walter Chang** and the Honolulu County Society's Scientific Program group and the Hawaii Academy of General Practice for somehow managing to gather over 200 physicians and their wives for a Sunday symposium. Moderator for the morning, disappointed **Ben Tom** looked over the few physicians present at 9:00 A.M. and worried if Lederle would ever sponsor another such fiasco, but by the hour before noon, the speakers were talking to a standing-room-only crowd and Ben's furrowed brow smoothed out and his frown turned to his usual happy grin. The first speaker introduced was **Dominis DeLaurentis,** Assistant Professor of Surgery from Temple University, who spoke methodically on the surgery of vascular trauma and emphasized resuscitation measures. Dominis was followed by **Leo Krall,** diabetes expert from Joslin Clinic, whose topic was "The Fat Man's Complaint—It's My Glands, Doc!" Leo debated the question, "Which is the greatest addiction, sex, food, or drugs?" He felt that Ben Tom with eight children certainly had a problem, but pointed out that man's primary urge is food and that as we grow older and other urges diminish, the primary food urge continues unabated. He described the American wife as an "automatic disposall" who is reluctant to throw away any food and consumes it instead. A helpful hint he dropped, though much too late for most of us, was that when one decides to marry a woman, he should look at her mother and grandmother and if he still likes their looks, go ahead and marry. Next, **Isadore Dyer,** Clinical Professor of OB & Gyn at Tulane, spoke on "The Fat, Pregnant Woman." Judging from these topics on obesity, we strongly suspect that Lederle may be trying to cut their luncheon budget for these sessions. There was an appreciable decrease in attendance after the luncheon and heads nodded as **David Pang** spoke at length as afternoon moderator. We listened to the same speakers covering staph infections in surgery, obesity, and diabetes and the "cute pelvis." Those who survived the afternoon qualified for the drinks and pupus in the Robert Louis Stevenson Room. ■

## News

### COURSE IN LARYNGOLOGY AND BRONCHOESOPHAGOLOGY

The Illinois Eye and Ear Infirmary and the College of Medicine of the University of Illinois at the Medical Center, Chicago, will conduct a postgraduate course in Laryngology and Bronchoesophagology from October 31 through November 12, 1966, under the direction of Paul H. Holinger, M.D. Instruction will be provided by means of animal demonstrations and practice in bronchoscopy and esophagoscopy, diagnostic and surgical clinics, as well as didactic lectures.

Interested registrants will please write directly to the Department of Otolaryngology, College of Medicine of the University of Illinois at the Medical Center, Post Office Box 6998, Chicago, Illinois 60680. The course is limited to 15 physicians.

### HAWAII CALENDAR

This feature has been supplanted by "What Goes On," a publication subsidized by Lederle Laboratories. "What Goes On" will be mailed to physicians in Hawaii and California nine times a year, beginning in August, 1966. If you have any suggestions which will make "What Goes On" more useful to you, the Hawaii Medical Association will appreciate receiving them.

### THE PHARMACIST REFLECTS

How often a puzzled patient looks at a label that says "As Directed" and says to the pharmacist, "But I forget what he said—how am I supposed to take this?" And the pressure on the pharmacist to supply customary or reasonable directions—instead of sending the patient back to the doctor for them—is often just irresistible. If the directions aren't impossibly lengthy or complex—like "One t.i.d." or "Two before breakfast"—how about writing them out, Doctor? It is the law, you know.

"As directed" is particularly bad when there's likely to be enough medicine left over to motivate a frugal patient to save it for next time. Six months later, "as directed" doesn't even convey any notion of what the medicine was **for**. But that won't stop many patients from guessing!

### SWEAT TESTS

Upon request of physicians, the Hawaii Chapter, National Cystic Fibrosis Research Foundation, will underwrite the cost of a diagnostic sweat test for cystic fibrosis on any child or adult in Hawaii. There is no means-test.

To make arrangements for free tests, telephone 576-665 or write to 550 Halekauwila St., Honolulu.

Your cystic fibrosis contributions are at work right here in Hawaii Nei.

### CORRECTION

Mrs. Noboru Oishi, the former Violet Niimi,—not, as was erroneously stated in *Our New President* in our last issue, Mrs. Calvin Kam—was the first Cherry Blossom Queen. Mrs. Kam is the former Shirley Ching.—ED.

## *Book Reviews* *continued from 45*

and abroad, is devoted to the more common conditions met with in adolescence. These include both physical and emotional problems, such as growth and development, adjustments to family and school conditions and how to deal with them. The more common diseases are also dealt with.

This book is a must for general practitioners and pediatricians in particular, and for anyone having much to do with the teen-age population.

D. C. MARSHALL, M.D.

### ★The Practice of Psychoanalytic Psychotherapy

*By Marc Hollender, M.D., 156 pp., $5.00, Grune and Stratton, 1965.*

THIS IS AN EXCELLENT textbook, primarily for residents in psychiatry who have sufficient background in the study of diagnosis and psychoanalytic dynamics to be able to recognize manifestations when they occur in patients. The book gives in great detail information regarding the selection of patients and the conducting of a long course of therapy. The author takes up the various resistances

encountered in patients during the beginning sessions of psychotherapy and gives rather detailed and systematic suggestions as to dealing with these defensive maneuvers. His discussion continues through the on-going "middle phase," in which he goes into a broad spectrum of varieties of treatment procedures, and discusses the approach to resolution of conflicts as they appear from different theoretical standpoints. His discussion of both technical and practical considerations is extremely informative and thorough. This section of the book should remain as a reference source for young therapists until they are sure of their capacity to handle all types of situations arising in the course of therapy.

His discussion of the termination of therapy adds a very important chapter to the resource material for students in this field, as it is a topic so rarely discussed in a practical and informed way.

The author's orientation is somewhat eclectic. He seems to have borrowed the best from all sources. This book fills admirably a long-felt need in the psychiatric field.

FRANCES COTTINGTON, M.D.

### ★Symposium on the Lens

*Sponsored by Visual Sciences Study Section and University of Minnesota, Supported by National Institute of Neurological Diseases and Blindness, National Institutes of Health, 381 pp., $18.50, The C. V. Mosby Company, 1965.*

THE TREMENDOUS AMOUNT of research done on the lens within recent years motivated this extensive symposium. The resulting text presents a masterpiece of organized research in the areas of embryology, morphology, electron microscopy, cytology, metabolism, and immunochemistry of the lens. The participants are outstanding leaders in ophthalmology and the allied sciences. The

*continued page 72*

WHEN YOU HAVE
A CALL TO MAKE
...CALL HAWAIIAN AIRLINES
FOR CONVENIENT JET FLIGHTS
TO ALL ISLANDS
WHETHER FOR
BUSINESS OR PLEASURE

FOR RESERVATIONS CALL:

| | | |
|---|---|---|
| HONOLULU | KAHULUI | LANAI |
| 817-611 | 75-011 | 3-222 |
| HANA | KAMUELA | LIHUE |
| 442-483 | 858-505 | 2-751 |
| HILO | KONA | MOLOKAI |
| 50-811 | 256-465 | 37-475 |

HAWAIIAN AIRLINES
Holder of the World's Safety Record

*When the problem is only skin deep*

USE 'POLYSPORIN'® brand
POLYMYXIN B-BACITRACIN
OINTMENT

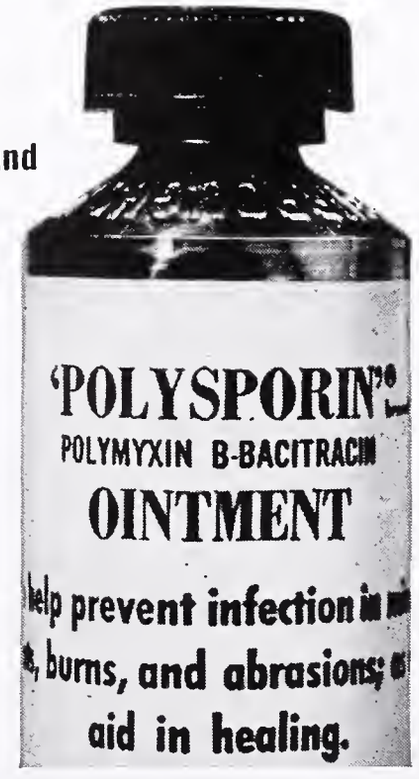
for topical antibiotic therapy with minimum risk of sensitization

Caution: As with other antibiotic products, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

Supplied in ½ oz. and 1 oz. tubes.

Complete literature available on request from Professional Services Dept. PML.

BURROUGHS WELLCOME & CO. (U.S.A.) INC.
Tuckahoe, N.Y.

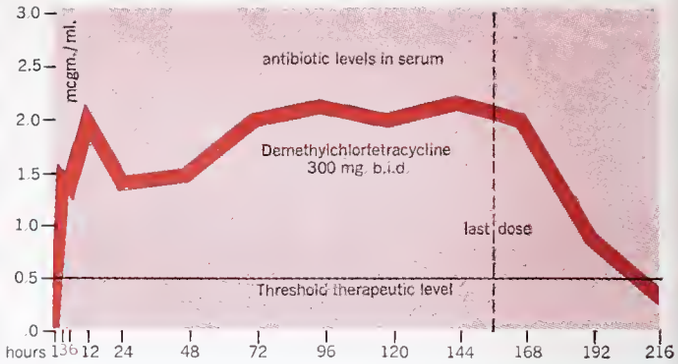




# greater potency

lower mg intake per day

600 mg versus 1,000 mg

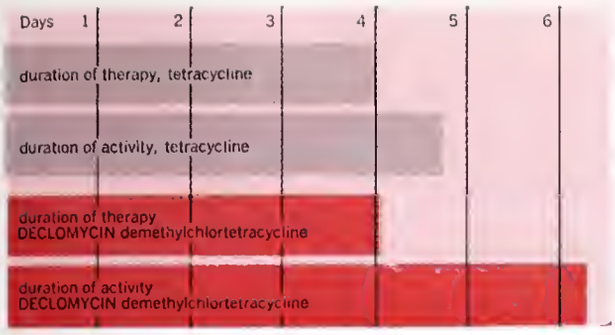



# higher activity

levels than ordinary tetracyclines

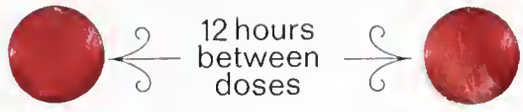
From Sweeney, W. M.; Dornbush, A. C., and Hardy, S. M.; Amer. J. Med. Sci. 243:296 (Mar.) 1962






# 1-2 days' "extra" activity

after the last dose to protect against relapse




one 300 mg Tablet
mid-morning

one 300 mg Tablet
mid-evening

# It's made for b.i.d.

# in G.U. infections

# broad-spectrum performance above and beyond the activity of ordinary tetracyclines

# DECLOMYCIN®

## DEMETHYLCHLORTETRACYCLINE

*Effective* in a wide range of everyday infections—respiratory, urinary tract and others—in the young and aged—the acutely or chronically ill—when the offending organisms are tetracycline-sensitive.

*Contraindication*—History of hypersensitivity to demethylchlortetracycline.

*Warning*—In renal impairment, usual doses may lead to excessive systemic accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of discomfort.

*Precautions and Side Effects*—Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. Use of demethylchlortetracycline during tooth development (last trimester of pregnancy, neonatal period and early childhood) may cause discoloration of the teeth (yellow-grey-brownish). This effect occurs mostly during long-term use but has also been observed in short treatment courses. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment. Side reactions include glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis and dermatitis. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Anaphylactoid reactions have been reported.

*Average Adult Daily Dosage:* 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products.

*Capsules:* 150 mg; *Tablets:* film coated, 300 mg, 150 mg, and 75 mg of demethylchlortetracycline HCl.

LEDERLE LABORATORIES, A Division of American Cyanamid Company, Pearl River, New York

656-6-3762

Lederle

FREE DELIVERY

CHARGE PRIVILEGES

*Our Pills and Potions Are the Best of the Best*
*Our Prescription Service Has Stood the Time Test*

SUMMERS PRESCRIPTION SHOPS

349 YOUNG BLDG.
576-378

416 ALA MOANA BLDG.
97-027

## *Book Reviews* *continued from 69*

profession owes a debt of gratitude to these men for making available information of such great interest and significance, in a well-presented volume form.

The discussions are numerous and stimulating. The references are extensive, as one would expect in such a research task. The whole subject of the lens and the perplexing problems associated with this minute structure will be enlightened by perusing this splendid work. The text is not light reading, but provokes an interest which is consuming when one has the time to sit down of a quiet evening and indulge in some deep ophthalmological thinking. Strongly recommended for the research minded.

HAROLD F. MOFFAT, M.D.

### ★Essentials of Gynecology, 3d Ed.

*By E. Stewart Taylor, M.D. 603 pp., $15.00, Lea & Febiger, 1965.*

THIS TEXTBOOK is the welcome revision of the previous edition by the author, who is interested in the medical students and the young practitioners of gynecology. In this edition of his textbook of gynecology, he provides broad coverage of the fundamentals and essentials of gynecology. The materials are well organized and readable. Physiology, anatomy, and pathology of gynecology are well correlated with clinical practice. Treatment of benign and malignant gynecological diseases is emphasized as is the management of endocrine disorders. On account of several innovations in endocrinology, cancer therapy, surgery for stress incontinence, and cytogenetics, many chapters have been extensively revised. Operative techniques and indications for vaginal and abdominal hysterectomy are discussed in principle and enough technical detail. However, the practitioner should refer to the available references for many other surgical procedures for the technical details of the operations.

This book contains many salient and valuable hints regarding etiology, diagnosis, and treatment of gynecologic disorders which we face daily in our medical practice. It should serve as a fine guide for the medical student and young practitioners who wish to learn gynecology. It will also be of great value to the busy clinicians and I recommend it highly for those who wish to have a good guide-line for the acceptable management of gynecologic disorders.

THOMAS K. OSHIRO, M.D.

### ★Hallux Valgus. Allied Deformities of the Forefoot and Metatarsalgia

*By H. Kelikian, M.D., 503 pp., $19.50, W. B. Saunders Company, 1965.*

THIS EFFECTIVE, well-organized, and well-illustrated 500-page book is an excellent guide for the management of problems relating to the forefoot. Over one-half of the book is devoted to detailed presentations of past and present operative procedures. Palliative measures, auxiliary surgical steps, and supplementary care are discussed in helpful detail. As a matter of fact, I found the book so helpful that I read it through from cover to cover. I would recommend it to any physician who treats disorders of the feet.

W. H. GULLEDGE, M.D.

## Also Received

### Methods in Medical Research, Vol. II

*Edited by Robert F. Rushmer, 301 pp., $10.25, Year Book Medical Publishers, 1966.*

AN EXCELLENT DISCUSSION on displacement and strain measurements, flow detection technics, microcirculation methods, measurement of force, tension, and pressure, and neurophysiologic technics. ■

*CONGRATULATIONS and BEST WISHES*

to

DR. HARRY L. ARNOLD, JR.

WILLIAMS MORTUARY, LTD.
1076 S. Beretania Street, Honolulu

HAWAIIAN MEMORIAL PARK MORTUARY CORP.
45-425 Kam Highway, Kaneohe

# Your stationery is a reflection of you... be certain the reflection is good!

*star-bulletin printing company*

*the hallmark of fine printing in honolulu*






**Boarding**
Finest, most modern facilities on the Island—automatic water fountains, etc.

**Professional Riding Instruction**
The best lesson horses in the state.

**Renting**
Riding trails.



**Camping**
Bunk house, Bar-B-Que, swimming pool, dressing rooms.

Birthday Parties Picnics Horses Sold Horses Leased

## HAWAII HORSE CENTER

**RICHARD E. PIGOTT**
**MANAGER**

**41-1791 KALANIANAOLE HWY.**
**WAIMANALO 96795**

**TELEPHONE**
**257-288**

# Our "Angels"


| | Page |
|---|---|
| Amfac, Inc. | 11 |
| American Tobacco Co. | 21 |
| Ames Company, Inc. | 75 |
| Ayerst Laboratories | 76 |
| Bishop Trust Co. | 57 |
| Bristol Laboratories | 18, 19, 62, 63 |
| Burroughs Wellcome & Co. | 69 |
| Carnation Company | 61 |
| Ciba Pharmaceutical Co. | 58, 59 |
| Coca-Cola Bottling Co. of Honolulu | 73 |
| Eastman Kodak | 50 |
| Gaspro, Ltd. | 53 |
| Geigy Pharmaceuticals | 10 |
| General Diagnostics | 51 |
| Hawaii Horse Center | 73 |
| Hawaii Medical Service Association | 12 |
| Hawaiian Airlines | 69 |
| Island Holidays | 64 |
| Kahanaola | 65 |
| Lederle Laboratories, Inc. | 70, 71 |
| Lilly, Eli, & Co. | 5, 24 |
| Medical Placement Bureau | 56 |
| Olds, Shirley | 3 |
| O'Leary, Lydia, of Hawaii | 64 |
| Optical Dispensers of Hawaii, Inc. | 56 |
| Parke, Davis & Co. | 2 |
| Physicians Ambulance Service | 74 |
| Pitman-Moore Company | 16, 17 |
| Robins, A. H., Co., Inc. | Insert (between 20, 21) |
| Roche Laboratories | 23 |
| Schuman Carriage Co., Ltd. | 60 |
| Searle, G. D., & Co. | 66, 67 |
| Squibb, E. R., & Sons | 20 |
| Star-Bulletin Printing Company | 73 |
| State Journals West Survey | Insert (between 50, 51) |
| Summer Pharmacies | 72 |
| Syntex Laboratories | 14, 15, 54, 55 |
| Tar Gard Company | 13 |
| Williams Mortuary | 72 |
| Wine Advisory Board | 22 |



OXYGEN AIR-CONDITIONED

*24-HOUR SERVICE*

Physician's



**510-477**

**AMBULANCE SERVICE, INC.**

***Hawaii's Finest***

November–December, 1966

# HAWAII MEDICAL JOURNAL




*In this issue*

## The Population Explosion – Con vs. Pro

## Usual and Customary Fees

*Table of contents, page 82*

VOLUME 26 • NUMBER 2

some allergens are red...

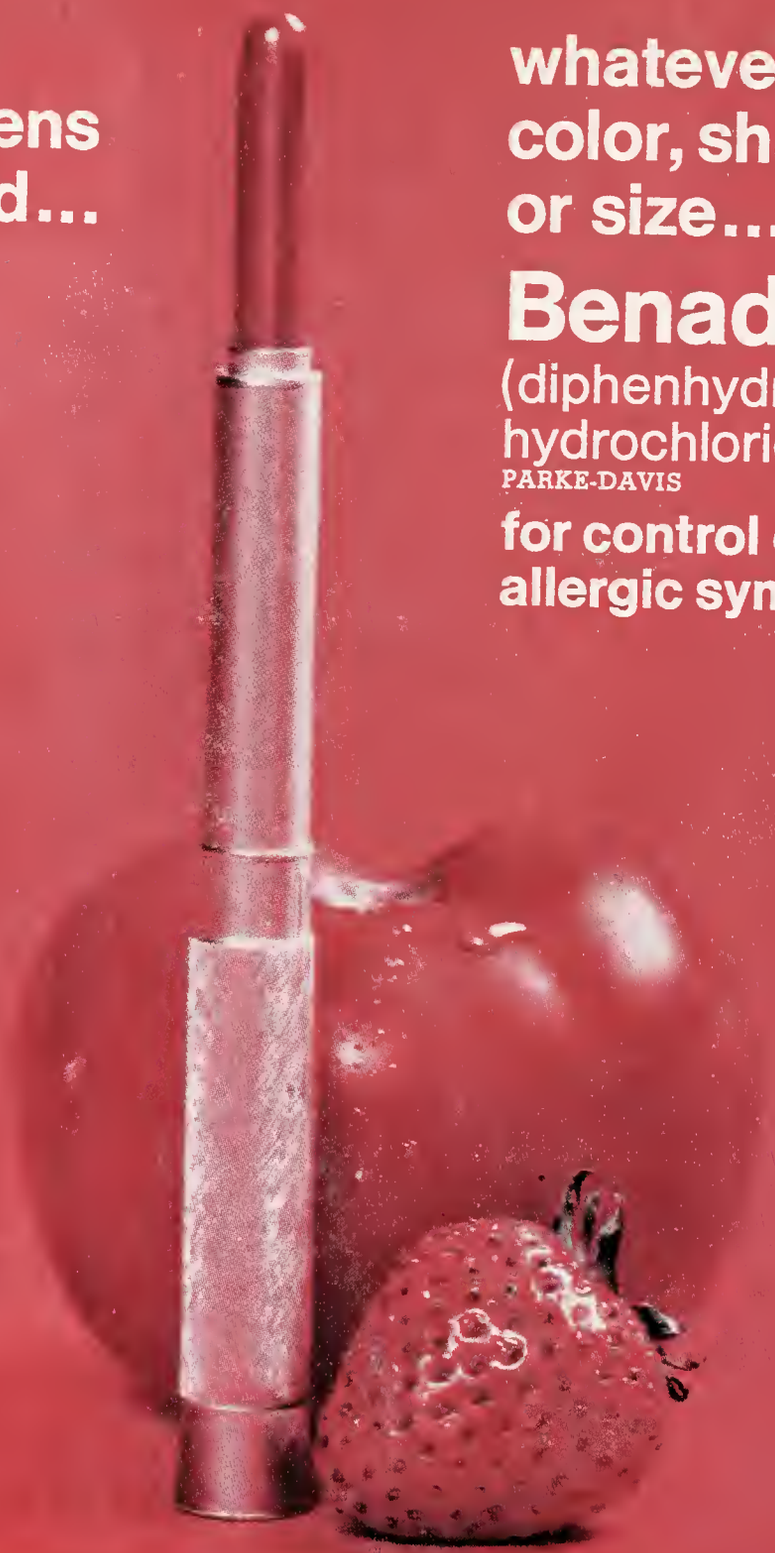
whatever their color, shape, or size...

# Benadryl®

(diphenhydramine hydrochloride)

PARKE-DAVIS

for control of allergic symptoms



Whether the allergen is red and round, or unseen and unknown, BENADRYL provides relief of symptomatic distress through its antihistaminic and antispasmodic actions. *PRECAUTIONS:* Persons who have become drowsy on this or other antihistamine-containing drugs, or whose tolerance is not known, should not drive vehicles or engage in other activities requiring keen response while using this product. Hypnotics, sedatives, or tranquilizers if used with BENADRYL should be prescribed with caution because of possible additive effect. Diphenhydramine has an atropine-like action which should be considered when prescribing BENADRYL. *SIDE EFFECTS:* Side reactions, commonly associated with antihistaminic therapy and generally mild, may affect the nervous, gastrointestinal, and cardiovascular systems. Most frequent reactions are drowsiness, dizziness, dryness of the mouth, nausea, and nervousness. BENADRYL is available in Kapseals® of 50 mg. and Capsules of 25 mg. 00666

PARKE-DAVIS

PARKE, DAVIS & COMPANY, Detroit, Michigan 48232

1866 1966 100th ANNIVERSARY

# MOLECULAR REMODELING—

## *laboratory exercise or clinical necessity?*

More than twenty-five years have passed since the discovery of the diuretic activity of sulfanilamide started pharmacologists on a succession of molecular remodelings to find the ideal diuretic.

### Diuresis—a sought-after clinical effect from an unwanted side effect

It started in 1937 when a clinician reported that the administration of a sulfonamide was sometimes accompanied by an unexplainable side effect—metabolic acidosis.[1] Three years later the side effect was explained. The sulfonamide radical of sulfanilamide inhibited carbonic anhydrase,[2] the enzyme responsible for converting carbon dioxide and water to hydrogen ions and bicarbonate ions.

Later, other investigators showed by dog experiments that metabolic acidosis probably resulted when the inhibition of carbonic anhydrase upset the exchange of hydrogen and sodium ions, causing increased excretion of sodium as the bicarbonate.[3]

It was twelve long years after the first report of the unexplainable side effect (metabolic acidosis) that it was finally shown that large doses of sulfanilamide administered to edematous patients were indeed capable of promoting diuresis.[4] However, the possibility of toxic effects from its prolonged use and its relatively weak diuretic action made it impractical for clinical use as a diuretic.[5]

Because the inhibition of carbonic anhydrase seemed to be the key to effective diuresis, investigators began to look for more potent enzyme inhibitors —in the hopes that they would be more effective diuretics.

The most important of these early compounds, acetazolamide, enjoyed several years of fairly wide clinical use.

Its carbonic anhydrase inhibitory activity was several hundred times greater than that of sulfanilamide.[6] The increase in inhibitory activity, however, increased not only the excretion of sodium and bicarbonate ions, but also the excretion of potassium.[7] And, like its predecessor, acetazolamide precipitated mild acidosis. Its prolonged use could result in hypokalemic acidosis.[7]

### The 'thiazides'—an answer to the metabolic acidosis caused by carbonic anhydrase inhibition

Despite the fact that the sulfonamide group appeared to be responsible for carbonic anhydrase inhibition which in turn appeared to be responsible for diuresis, investigators began to synthesize compounds with structural alterations to the sulfonamide group.

The first major breakthrough came with the synthesis of chlorothiazide. Altering the sulfonamide group did indeed alter the ability of chlorothiazide to inhibit carbonic anhydrase—it was only 1/10th as potent as acetazolamide in inhibiting the enzyme.[8] Despite the drop in inhibitory potency, however, chlorothiazide proved to be an effective diuretic—an observation that led to the conclusion that its diuretic action was due to some mechanism other than its action on carbonic anhydrase.[9,10]

For effective diuresis, chlorothiazide was administered in daily dosages ranging from 250 to 2000 mg.[11] It increased the excretion of sodium and chloride; and, to a lesser extent, potassium and bicarbonate.[11] The excretion of potassium appeared to be maximal at higher dose levels at which, theoretically, the carbonic anhydrase inhibitory effect is more active.[11] Its prolonged use, therefore, could sometimes result in metabolic hypokalemic, hypochloremic alkalosis.[7]

### Naturetin—effective diuresis with more favorable electrolyte balance

Other thiazides followed—with improvements being aimed at two particular areas: 1. attempts to increase diuretic action in relation to the milligram potency of the drug, and 2. attempts at a more favorable sodium/potassium ratio in the urine, i.e., to decrease the excretion of potassium while maintaining the excretion of sodium.[12]

One of these, Naturetin, Squibb Bendroflumethiazide, has made advances on both these points. "By adding a 3-benzyl radical to hydroflumethiazide a rather dramatic reduction in dose range is accomplished. With this drug, effective sodium excretion is obtained with doses between 2.5 and 10 mg., which is a 200 to 1 ratio as compared to chlorothiazide..."[13]

Moreover, due probably to its virtual lack of carbonic anhydrase inhibition, Naturetin (bendroflumethiazide) has been shown to cause less potassium and bicarbonate loss and less alteration in urinary pH than either chlorothiazide or hydrochlorothiazide.

Naturetin is outstandingly effective not only in establishing, but also in maintaining, excretion of retained fluid in edematous patients. And its duration of action is sufficiently prolonged to allow a single daily administration in most patients. Naturetin is also an effective antihypertensive agent.

**Contraindications:** Severe renal impairment; previous hypersensitivity.

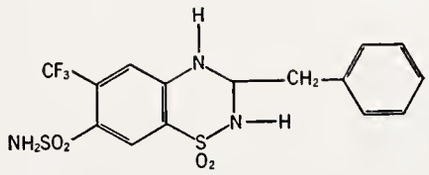
**Warning:** Ulcerative small bowel lesions have occurred with potassium-containing thiazide preparations or with enteric-coated potassium salts supplementally. Stop medication if abdominal pain, distension, nausea, vomiting, or G.I. bleeding occur.

**Precautions:** The dosage of ganglionic blocking agents, veratrum, or hydralazine when used concomitantly must be reduced by at least 50% to avoid orthostatic hypotension. Electrolyte disturbances are possible in cirrhotic or digitalized patients.

**Side Effects:** Bendroflumethiazide may cause increases in serum uric acid, unmask diabetes, increase glycemia and glycosuria in diabetic patients and may cause hypochloremic alkalosis, hypokalemia; cramps, pruritus, paresthesias, and rashes may occur.

**Supplied:** Naturetin (Squibb Bendroflumethiazide) 5 mg. and 2.5 mg. tablets. Also available Naturetin c K [Squibb Bendroflumethiazide (5 or 2.5 mg.) with Potassium Chloride (500 mg.)]. For full information, see Product Brief.

**References:** **1.** Southworth, H.: Proc. Soc. Exper. Biol. & Med. *36*:58, 1937. **2.** Mann, T. and Keilin, D.: Nature *146*:164, 1940. **3.** Pitts, R. F., and Alexander, R. S.: Am. J. Physiol. *144*:239, 1945. **4.** Schwartz, W. B.: New England J. Med. *240*:173, 1949. **5.** Friedberg, C. K., in Moyer, J. H., and Fuchs, M.: Edema Mechanisms and Management, Philadelphia, W. B. Saunders Co., 1960, p. 259. **6.** Cumming, J. R.; Tabachnick, E., and Seelig, M., in Moyer, J. H., and Fuchs, M.: op. cit., p. 254. **7.** Werko, L., in Moyer, J. H., and Fuchs, M.: op. cit., p. 188. **8.** Beyer, K. H., Jr., in Moyer, J. H., and Fuchs, M.: op. cit., p. 274. **9.** Maren, T. H., and Wiley, C. E.: J. Pharmacol. & Exper. Therap. *143*:230, 1964. **10.** Earley, L. E., and Orloff, J.: Ann. Rev. Med. *15*:149, 1964. **11.** Fuchs, M., and Mallin, S. R., in Moyer, J. H., and Fuchs, M.: op. cit., p. 276. **12.** Ford, R. V., in Moyer, J. H., and Fuchs, M.: op. cit., p. 290. **13.** cited in Fuchs, M., and Mallin, S. R. (ref. 11): op. cit., p. 283.




Naturetin®
SQUIBB BENDROFLUMETHIAZIDE
to reduce excess fluid
or high blood pressure

HAWAII MEDICAL JOURNAL

*Published Bi-Monthly by the* HAWAII MEDICAL ASSOCIATION (Incorporated in 1856 under the Monarchy), 510 S. Beretania St., Honolulu, Hawaii 96813 • *Editor,* HARRY L. ARNOLD, JR., M.D. • *News Editor,* HENRY N. YOKOYAMA, M.D. • *Managing Editor,* LEE MCCASLIN

VOLUME 26, NUMBER 2 • NOVEMBER-DECEMBER, 1966 • $6.00 A YEAR, $1.00 A COPY

The JOURNAL may not be held responsible for opinions expressed in papers, discussions, communications, or advertisements. The advertising policy of the HAWAII MEDICAL JOURNAL is governed by the rules of the Council on Drugs of the American Medical Association. The right is reserved to reject material submitted for editorial or advertising columns. All material for publication must be in the hands of the editor on or before the 10th day of the month preceding publication date. Reprints of original articles will be supplied at actual cost, provided request is attached to manuscript or made in sufficient time before publication. A reasonable number of cuts and illustrations accompanying an article will be accepted for printing. The right is reserved to ask the author to bear cost of these when it is found necessary to do so.

Copyright, 1966, by the Hawaii Medical Association, Honolulu, Hawaii. Entered as second class matter, October 17, 1941, at the Post Office in Honolulu, Hawaii, under the Act of August 24, 1912. Office of Publication: Mabel L. Smyth Memorial Building, 510 S. Beretania St., Honolulu, Hawaii 96813.

# The Hawaii Medical Association

## Officers 1966-1967

President • THEODORE T. TOMITA, *Honolulu*
President-Elect • B. A. RICHARDSON, *Honolulu*
Past President • O. D. PINKERTON, *Honolulu*
Secretary • R. VARIAN SLOAN, *Honolulu*
Treasurer • HERBERT Y. H. CHINN, *Honolulu*

County Presidents

Hawaii County • ED B. HELMS, *Hilo*
Honolulu County • JOHN J. LOWREY, *Honolulu*
Kauai County • Y. MIYASHIRO, *Waimea*
Maui County • KENNETH HALING, *Kahului*

Delegate to A.M.A. • RICHARD D. MOORE, *Honolulu*
Alt. Delegate to A.M.A. • GEORGE H. MILLS, *Honolulu*

## Councillors 1966-1967

Maui • JOSEPH E. ANDREWS
Honolulu • GROVER H. BATTEN
Honolulu • BERNARD W. D. FONG
Honolulu • ANDREW C. IVY, JR.
Hawaii • ROBERT M. MIYAMOTO
Kauai • SAMUEL R. WALLIS

## Officers—County Societies—1966

| HAWAII | | HONOLULU |
|---|---|---|
| ED B. HELMS • | President | • JOHN J. LOWREY |
| ETTA WRIGHT BEST • | Vice President | • GEORGE H. MILLS |
| CHARLES H. BELCHER • | Secretary | • KEITH F. O. KUHLMAN |
| PAUL CALDWELL • | Treasurer | • HERBERT Y. H. CHINN |

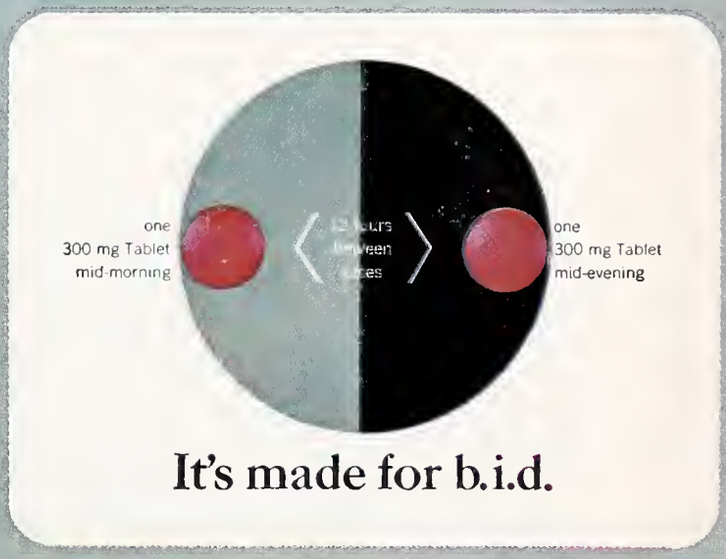
| KAUAI | | MAUI |
|---|---|---|
| Y. MIYASHIRO • | President | • KENNETH HALING |
| SAMUEL WALLIS • | Vice President | • BILLIE FERN STROTHER |
| JAMES P. WARNER • | {Secretary} {Treasurer} | • SAKAE UEHARA |

# why wonder about a drug

## when you know

# DECLOMYCIN®
# DEMETHYLCHLORTETRACYCLINE

## is effective b.i.d.




**It's made for b.i.d.**

*Effective* in a wide range of everyday infections—respiratory, urinary tract and others—in the young and aged—the acutely or chronically ill—when the offending organisms are tetracycline-sensitive.

*Contraindication*—History of hypersensitivity to demethylchlortetracycline.

*Warning*—In renal impairment, usual doses may lead to excessive systemic accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort.

*Precautions and Side Effects*—Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. Use of demethylchlortetracycline during tooth development (last trimester of pregnancy, neonatal period and early childhood) may cause discoloration of the teeth (yellow-grey-brownish). This effect occurs mostly during long-term use but has also been observed in short treatment courses. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment. Side reactions include glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis and dermatitis. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Anaphylactoid reactions have been reported.

*Average Adult Daily Dosage:* 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products.

*Capsules:* 150 mg; *Tablets:* film coated, 300 mg, 150 mg, and 75 mg of demethylchlortetracycline HCl.

Lederle LEDERLE LABORATORIES
A Division of American Cyanamid Company, Pearl River, New York
433-6-4102

HAWAII MEDICAL JOURNAL

# Contents

Volume 26, No. 2 • November-December, 1966

**Articles**

*Somebody's Going to Get Killed* 105
William N. Bergin, M.D.

*Early Fertility-Management Concepts in China* 110
Amrit Lal, Ph.M., M.A. (Eco), L.M.S.H., Delhi, India

*The Relative Value Studies: Fixed Conversion vs. Customary Fees* 115
Robert L. Thomas

*Immunogenetic Studies on Mongolism* 121
Mitsuo Yokoyama, M.D.

*Childhood Leukemia in Hawaii Experience at Kauikeolani Children's Hospital* 125
Claude D. Lauriault, M.D., and Robert T. S. Jim, M.D.

**Editorials**

*Foundation for Medical Care* 128
*The Aloha United Fund: Preliminary Report* 129
*Looking for Lost IUD's* 129

**Features**

*Book Reviews* 133
*Correspondence* 142
*County Society Reports* 135
*Hawaii Academy of General Practice* 130
*Hawaii Medical Association* 138
*In Memoriam—Doctors of Hawaii—LXIV* 132
*New Members* 134
*Notes and News* 136
*Poetry: Loopus Benignus or The Sperm That Turned* 114
*President's Page* 127
*This Is What's New!* 131

**Hawaii Technologists' Bulletin**

*A Med Tech in Asia* 140

# FOUR NEW FACES



Masao Miyataki
Salesman—Oahu



Dorothy Sakabe
Inside Sales
—Oahu



Tokio Hikida
Warehouseman



Toshio Yamashita
Warehouseman

# SAME OLD DEPENDABLE SERVICE



Charles Malang
MANAGER

Now there are 21 people in the AMFAC DRUG Department to serve you. 21 people who understand that fast delivery is absolutely necessary. 21 able and determined people . . . to back you up with service so dependable it can be taken for granted.



Johnny Kawafuchi
Sales Manager



Kenny Hills
Salesman—Oahu



Frankie Fernandez
Salesman—Oahu



Hideo Kawabata
Salesman—Oahu



Bill Lindsey
Salesman—Oahu



George Pereira
Buyer



Christine Oga
Inside Sales
—Oahu



Edna Sato
Inside Sales
—Oahu



Doris Uyeda
Inside Sales
—Oahu



Elizabeth Azevedo
Inside Sales
—Oahu



Eileen Brenessel
Secretary



Donald Hangai
Warehouseman



Hans Yoshino
Warehouseman



Shiro Sodetani
Warehouseman



Masaaki Sasaki
General Sales
—Hawaii



Yoriyoshi Hara
Salesman—Hawaii

APPLICATORS • DESENEX • DRUG ENVELOPES • ETHER • LYSOL • MAZON • OINTMENT TINS

Alcon Laboratories
Allergan Pharmaceutical
Arbrook
Ames Co.
Astra Pharm. Products, Inc.
Ayerst Laboratories, Inc.
Bard-Parker
Barnes-Hind Laboratories
Becton-Dickinson & Company
Bristol Laboratories
Brockway Glass Company
Burroughs Wellcome & Co.
Carnrick Laboratories
CIBA Pharmaceutical Prod., Inc.
Conal Pharmaceutical, Inc.
Davis & Geck Sutures
Dome Chemicals, Inc.
Drug Package Inc.
Eaton Laboratories
Endo Laboratories
Ethicon Jnc.
Hynson, Westcott, Dunning
Invenex Pharmaceuticals
Johnson & Johnson
Kirkman Pharmaceutical Company
Lederle Laboratories
Mallinskrodt Chemical Works
McNeil Laboratories
Mead-Johnson & Company
Merrell, William S.
Minnesota Mining & Mfg. Co.
Organon, Inc.
Ortho Pharmaceutical Corp.
Owen Laboratories
Pfizer Laboratories
Pitman-Moore Company
Ray-O-Vac Company
Riker Laboratories, Inc.
A. H. Robins Co., Inc.
Roche Laboratories
J. B. Roerig & Company
Sandoz Pharmaceuticals
Sauter Laboratories
Schering Corp.
The Scholl Mfg. Co., Inc.
Searle & Co., G. D.
Smith, Kline & French Lab.
Stanlabs, Inc.
Strong-Cobb-Arner, Inc.
Stuart Company
Tampax Inc.
Tidi Products
Travenol Labs, Inc.
U. S. Vitamin & Pharmaceutical Corp.
Vestal Laboratories, Inc.
Wallace Laboratories
Warner-Chilcott Lab.
Warren-Teed Pharmaceuticals
Westwood Pharmaceuticals
Winthrop Products, Inc.

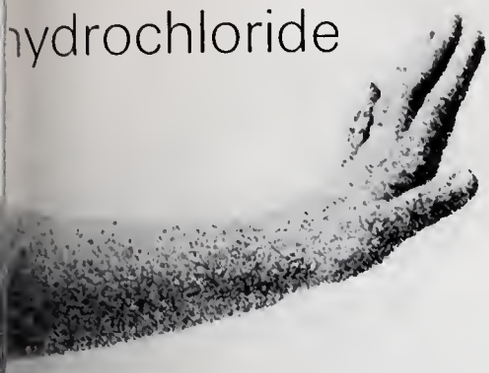
OSYL • Rx BOTTLES • Rx FILES • PILL BOXES • TONGUE BLADES • X-RAY FILMS & SUPPLIES

**SAME-DAY DELIVERIES • SCHEDULED RURAL DELIVERIES**
Phone 585-531 between 7:30 a.m. and 4:30 p.m. weekdays

**AMFAC INC DRUG DEPARTMENT**



# Preludin®
## phenmetrazine hydrochloride





# helps keep calories at arm's length

In one double-blind program* involving diet, close doctor/patient cooperation, exercise, posture instruction, and follow-up visits, 93 obese patients received Preludin or a placebo. The drug and placebo were alternated every four weeks. This procedure lasted from 8 to 35 weeks.

Sixty-one percent of the patients lost more weight on Preludin than on placebo. In fact, they lost an average 1.9 pounds per week—almost four times as much as when they were on placebo!

For a decade Preludin has demonstrated similar results. Its effectiveness has been described in more than 300 published clinical reports involving more than 10,000 patients.

Preludin curbs appetite without excessive stimulation. It will work in your weight-control programs too.

*Barnes, R. H.: J.A.M.A. 166:898, 1958.

Preludin® tablets of 25 mg.
Endurets® prolonged-action tablets of 75 mg.
*Dosage:* One 25 mg. tablet two or three times daily, or one 75 mg. Endurets tablet once daily.
*Contraindications:* Severe coronary artery disease, hyperthyroidism, severe hypertension, nervous instability, and agitated prepsychotic states. Do not use with other CNS stimulants, including MAO inhibitors.
*Warning:* Do not use during the first trimester of pregnancy unless potential benefits outweigh possible risks.
*Precautions:* Use with caution in *moderate* hypertension and cardiac decompensation. Excessive use may result in a psychotic illness manifested by restlessness, mood or behavior changes, hallucinations, or delusions.
*Side Effects:* Dryness or unpleasant taste in the mouth, urticaria, and (rarely) overstimulation, insomnia, dizziness, nausea, or headache.

For details, see full Prescribing Information. 6544-III (B)

Under license from Boehringer Ingelheim G.m.b.H.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation, Ardsley, N.Y.

# How long will it take her to recover from her hip fracture if she just doesn't care?



**Does she really care? Is she alert, encouraged, positive and optimistic about getting completely well soon?**

**Or has she given in to the demoralizing impact of confinement, disability and dependency?**

**When functional fatigue complicates convalescence, Alertonic can help...**

Pleasant-tasting Alertonic is pipradrol hydrochloride—an effective cerebral stimulant whose gentle analeptic action helps counteract the apathy and inertia that can often delay convalescence—together with an excellent vitamin and mineral formula, in a satisfying 15% alcohol vehicle.

Nothing fosters confidence and a sense of well-being better than your own personal warmth, understanding and encouragement together with Alertonic to help insure prompt response.

*Adequate dosage is important: Prescribe Alertonic—one tablespoonful t.i.d., 30 minutes before meals...tastes best chilled.*

*And for your patient's sake, prescribe Alertonic in the convenient, economical one-pint bottle.*

# Alertonic®

*Available Only On Prescription*

Each 45 cc. (3 tablespoonfuls) contains: alcohol, 15%; pipradrol hydrochloride, 2 mg.; thiamine hydrochloride (vitamin $B_1$) (10 MDR*), 10 mg.; riboflavin (vitamin $B_2$) (4 MDR), 5 mg.; pyridoxine hydrochloride (vitamin $B_6$), 1 mg.; niacinamide (5 MDR), 50 mg.; choline,† 100 mg.; inositol,† 100 mg.; calcium glycerophosphate, 100 mg. (supplies 2% MDR for calcium and for phosphorus) and 1 mg. each of the following: cobalt (as chloride), manganese (as sulfate), magnesium (as acetate), zinc (as acetate), and molybdenum (as ammonium molybdate).

*Multiple of adult Minimum Daily Requirement supplied.
†The need for these substances in human nutrition has not been established.

*Indications:* 1. Functional fatigue such as that often associated with: a depressing life experience or stressful time of life; advancing years; convalescence; limited activity or confinement. 2. Poor appetite and vitamin-mineral deficiency as they occur in: patients having faulty eating habits; geriatric patients who are losing interest in food; patients convalescing from debilitating illness or surgery.

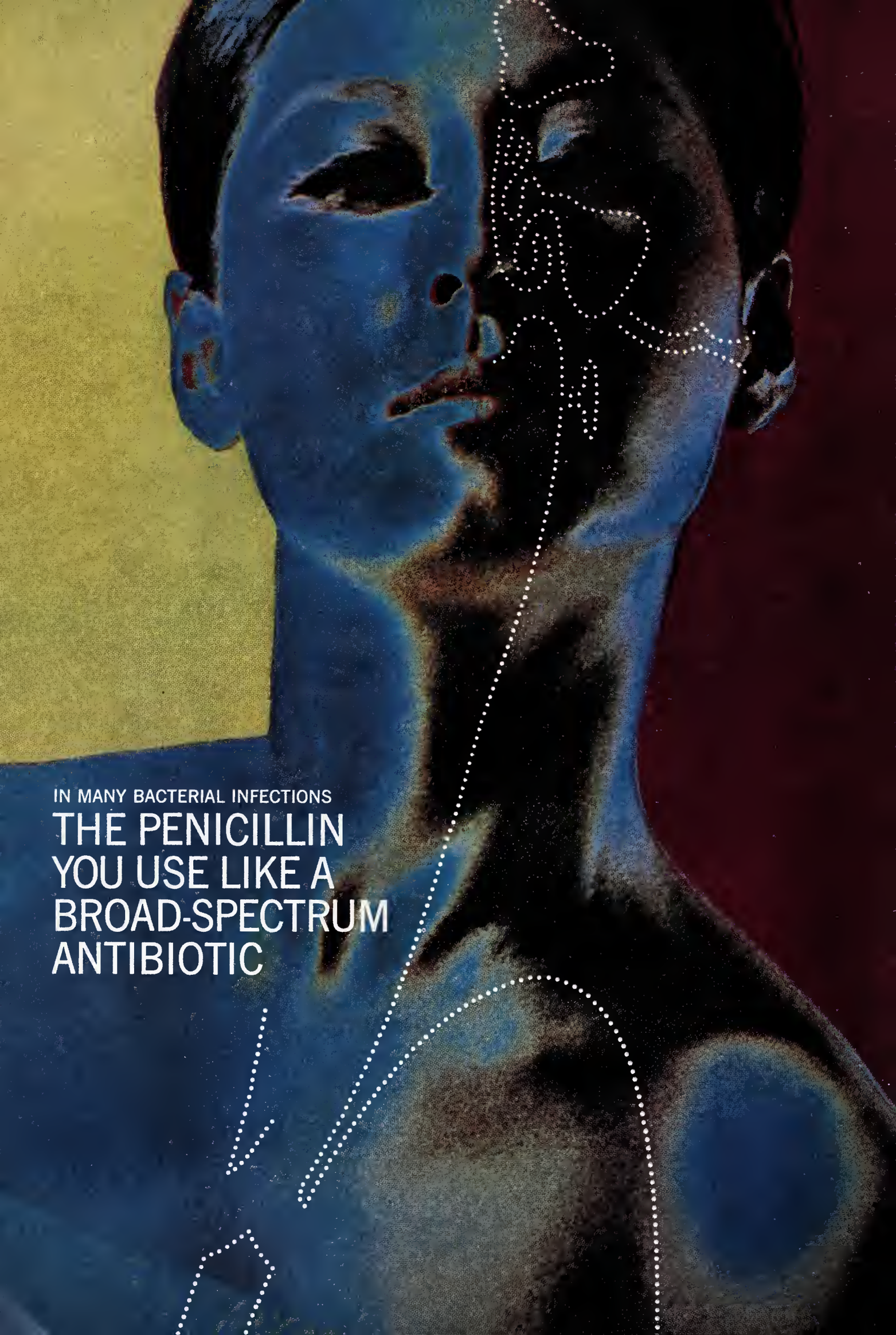
*Dosage:* Adults, 1 tablespoonful; children (over 15 years old), 1 to 2 teaspoonfuls; children (4 to 15 years old), 1 teaspoonful. To be taken three times daily 30 minutes before meals.

*Contraindications:* As with other drugs with CNS stimulating action, Alertonic is contraindicated in hyperactive, agitated or severely anxious patients and in chorea or obsessive compulsive states.

*Side effects:* Reports of overstimulation have been rare. Patients who are known to be unduly sensitive to the effects of stimulant drugs should be observed carefully in the initial stages of treatment.

Merrell

THE WM. S. MERRELL COMPANY
Division of Richardson-Merrell Inc.
Cincinnati, Ohio 45215


IN MANY BACTERIAL INFECTIONS
THE PENICILLIN YOU USE LIKE A BROAD-SPECTRUM ANTIBIOTIC

# NOW BASIC BACTERICIDAL ANTIBIOTIC THERAPY IN RESPIRATORY INFECTIONS

**Replaces bacteriostatic agents**
Instead of older, essentially bacteriostatic broad-spectrum agents, you can now treat respiratory infections with the first broad-spectrum penicillin—bactericidal, well tolerated Polycillin (ampicillin trihydrate).

Polycillin (ampicillin trihydrate) is highly effective against Gram-positive organisms such as *D. pneumoniae*, and streptococci, and in addition, is more active than either tetracycline or chloramphenicol against *H. influenzae* and many other Gram-negative pathogens. (Note: ampicillin is not indicated for resistant staphylococci.)

**The safety of a penicillin**
Like traditional penicillins, Polycillin (ampicillin trihydrate) is well tolerated and devoid of direct toxicity—in contrast to older broad-spectrum agents, which can be toxic in therapeutic dosage. As with any penicillin, the possibility of allergic reaction should be considered.

**Widely useful and highly effective**
From ENT infections in children to chronic bronchitis and pneumonitis in adults, Polycillin (ampicillin trihydrate), has come to be accepted as *basic* antibiotic therapy. In a recent series of 270 patients with upper and lower respiratory infections, cured or improved responses occurred in 97.4 per cent.*

**Available forms and strengths allow broad applications**
Prescribe the unit dosage and route of administration best suited for the severity of infection and duration of therapy.
Polycillin (ampicillin trihydrate) Capsules—250 mg., bottles of 24 and 100; 500 mg., bottles of 16 and 100.
For Oral Suspension—125 mg./5 ml., bottles of 60 ml., 80 ml. and 150 ml.; 250 mg./5 ml., bottles of 80 ml.
Polycillin-N™ (sodium ampicillin) for I.M./I.V. injection, vials of 250 and 500 mg.

BRISTOL THERAPEUTIC SUMMARY.
For complete information, consult Official Package Circular.
*Indications:* Infections due to susceptible strains of Gram-negative bacteria (including Shigellae, *S. typhosa* and other Salmonellae, *E. coli*, *H. influenzae*, *P. mirabilis*, *N. gonorrhoeae* and *N. meningitidis*) and Gram-positive bacteria (including streptococci, pneumococci and nonpenicillinase-producing staphylococci).
*Contraindications:* A history of serious allergic reactions to penicillin and infections due to penicillinase-producing organisms.
*Precautions:* Typical penicillin-allergic reactions may occur, especially in hypersensitive patients. Mycotic or bacterial superinfection may occur. Experience in newborn and premature infants is limited and caution should be used in treatment, with frequent organ function evaluations. Safety for use in pregnancy is not established. In gonorrheal therapy, serologic tests for syphilis should be performed initially and monthly for 3 months. Assess renal, hepatic and hematopoietic function intermittently during long-term therapy.
*Adverse Reactions:* Skin rash, pruritus, urticaria, nausea, vomiting, diarrhea and anaphylactic reactions. Mild transient elevations of SGOT or SGPT have been noted.
*Usual Dosage:* Adults—250 or 500 mg. *q.* 6 *h.* (according to infection site and offending organisms). Children—50-100 mg./Kg./day in 3 to 4 divided doses (depending on infection site and offending organisms). Children weighing more than 20 Kg. should be given an adult dose. Beta-hemolytic streptococcal infections should be treated for at least 10 days.

*Data on file, Medical Department, Bristol Laboratories.

BRISTOL
BRISTOL LABORATORIES
Division of Bristol-Myers Co.
Syracuse, New York

**Polycillin®**
(ampicillin trihydrate)




SAXON

*A common cold! I thought everything was a "virus" these days.*

Although he'd prefer a more exotic name for it, you know he's suffering from an ordinary, old common cold. And, he's congested. He'll breathe easier when you prescribe Novahistine LP.

Two long-acting tablets in the morning and two in the evening will provide around-the-clock relief by helping to keep congested air passages clear, thus enabling your cold patient to enjoy normal and free breathing. This action of long-acting Novahistine LP helps restore normal mucus secretion and ciliary activity—physiologic defenses against infection of the respiratory tract.

Use cautiously in individuals with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Tell patients who operate machinery or motor vehicles that drowsiness may result.

Each Novahistine LP tablet contains: phenylephrine hydrochloride, 25 mg., and chlorpheniramine maleate, 4 mg.

# NOVAHISTINE® LP

*For relief of nasal congestion.*

DOW **PITMAN-MOORE** Division of The Dow Chemical Company, Indianapolis



# Carnation
EVAPORATED MILK

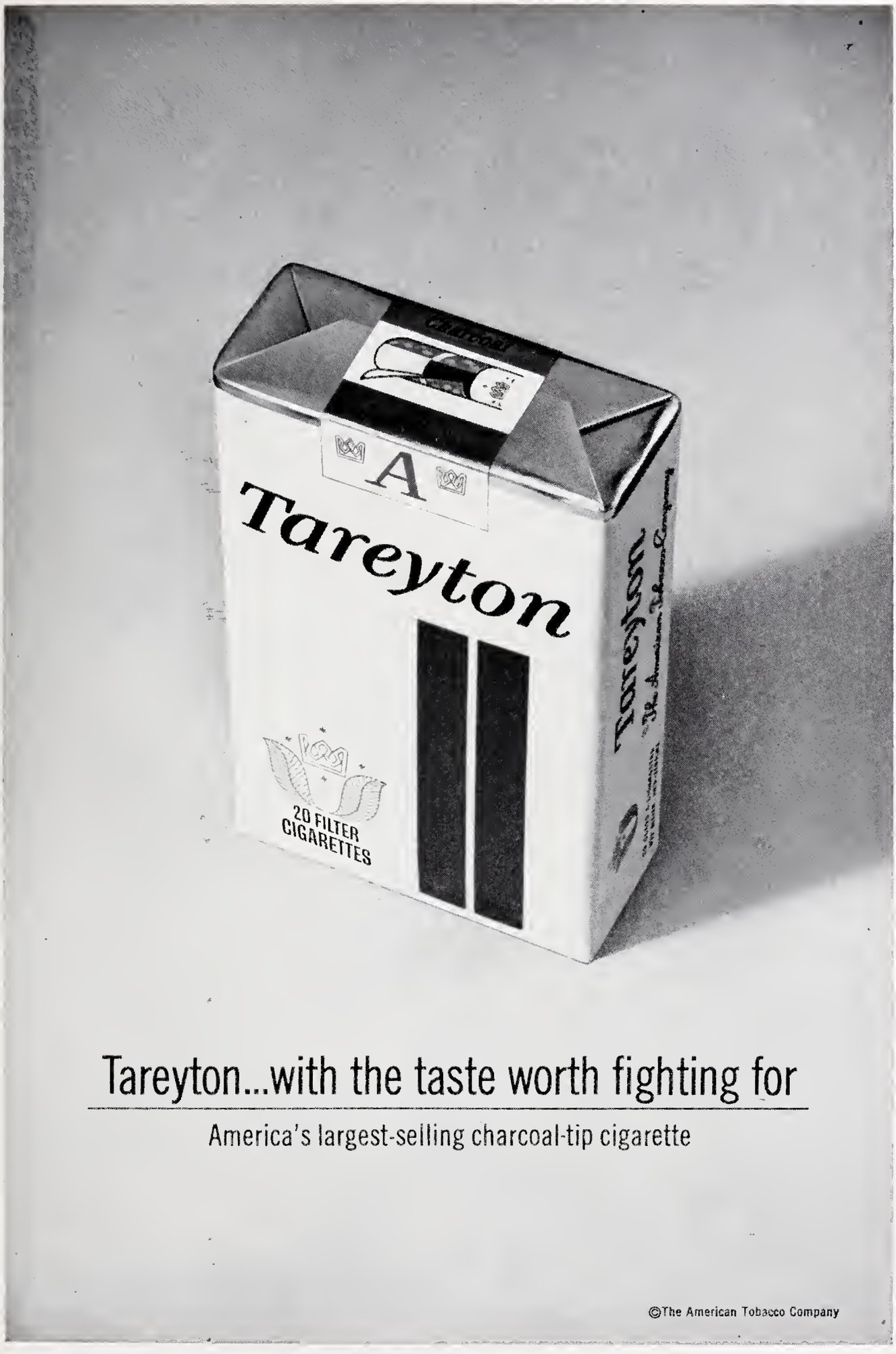



1965
Carnation Healthy Baby Contest
$1,000 1st prize winner,
Laurie Anne Medeiros
of Honolulu, Hawaii

**HAWAII'S HEALTHY BABY MILK...**

***1st CHOICE FOR INFANT FEEDING...***
***No. 1 in the Islands for generations,***
***...available everywhere in Hawaii***

*"from Contented Cows"*




Tareyton...with the taste worth fighting for

America's largest-selling charcoal-tip cigarette

©The American Tobacco Company

# block end runs



# LOMOTIL®

tablets/liquid

Each tablet and each 5 cc. of liquid contains:
diphenoxylate hydrochloride..... 2.5 mg.
(Warning: May be habit forming)
atropine sulfate .....0.025 mg.

# tackles the problem of diarrhea directly

**Effectiveness**—Physiologic evidence indicates that Lomotil acts directly on the smooth muscle of the bowel to lower motility and control diarrhea. This action is unsurpassed in promptness and efficiency.

**Convenience**—Lomotil is available as small, easily carried, virtually tasteless tablets and as a pleasant, fruit-flavored liquid

**Versatility**—The therapeutic efficiency, safety and convenience of Lomotil may be used to advantage alone or adjunctively in diarrhea associated with:

**• Functional hypermotility • Acute infections • Malabsorption syndrome • Drug therapy • Gastroenteritis and colitis • Irritable bowel • Regional enteritis • Ileostomy • Ulcerative colitis • Food poisoning**

*For correct therapeutic effect*
*Rx correct therapeutic dosage*

*Dosage:* The recommended initial daily dosages, given in divided doses until diarrhea is controlled, are:

**Children: Total Daily Dosage**

3-6 mo. . .½ tsp.* t.i.d. (3 mg.)
6-12 mo. .½ tsp. q.i.d. (4 mg.)
1-2 yr. . . .½ tsp. 5 times daily (5 mg.)
2-5 yr. . . .1 tsp. t.i.d. (6 mg.)
5-8 yr. . . .1 tsp. q.i.d. (8 mg.)
8-12 yr. . .1 tsp. 5 times daily (10 mg.)

**Adults:** 2 tsp. 5 times daily (20 mg.)
(or 2 tablets q.i.d.)

*Based on 4 cc. per teaspoonful.

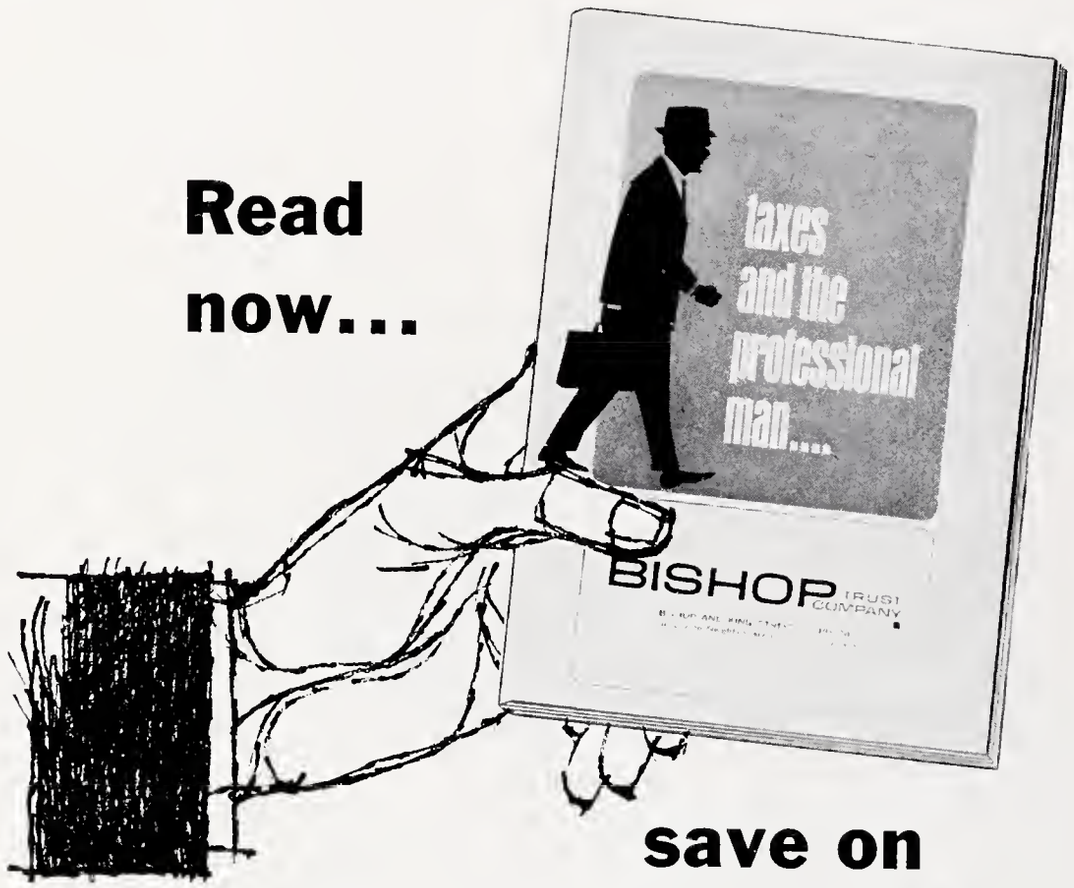
Maintenance dosage may be as low as one-fourth the initial daily dosage.

*Precautions:* Lomotil, brand of diphenoxylate hydrochloride with atropine sulfate, is a Federally exempt narcotic preparation of very low addictive potential. Lomotil should be kept out of reach of children since accidental overdosage may cause severe respiratory depression. Recommended dosages should not be exceeded. Lomotil should be used with caution in patients with impaired liver function and in patients taking addicting drugs or barbiturates. The subtherapeutic amount of atropine is added to discourage deliberate overdosage.

*Side Effects:* Side effects are relatively uncommon but among those reported are gastrointestinal irritation, sedation, dizziness, cutaneous manifestations, restlessness, insomnia, numbness of extremities, headache, blurring of vision, swelling of the gums, euphoria, depression and general malaise.

SEARLE *Research in the Service of Medicine*

# Read now...




# save on taxes later!

If you are concerned about your family's financial future — how best to conserve money you are making now for their future use — you should read "Taxes and the Professional Man."

Written especially for professional men, it explains important aspects of Federal estate and gift taxes. How they may be minimized by sound planning. How trusts may serve your purposes. How the professional man who works for a corporation or institution should plan. Examples are included.

For a copy of "Taxes and the Professional Man," just write or call:

60 ANNIVERSARY 1895 1955

**BISHOP TRUST COMPANY**

*Trust Services Exclusively*

BISHOP AND KING STREETS · PHONE 563-771 ■



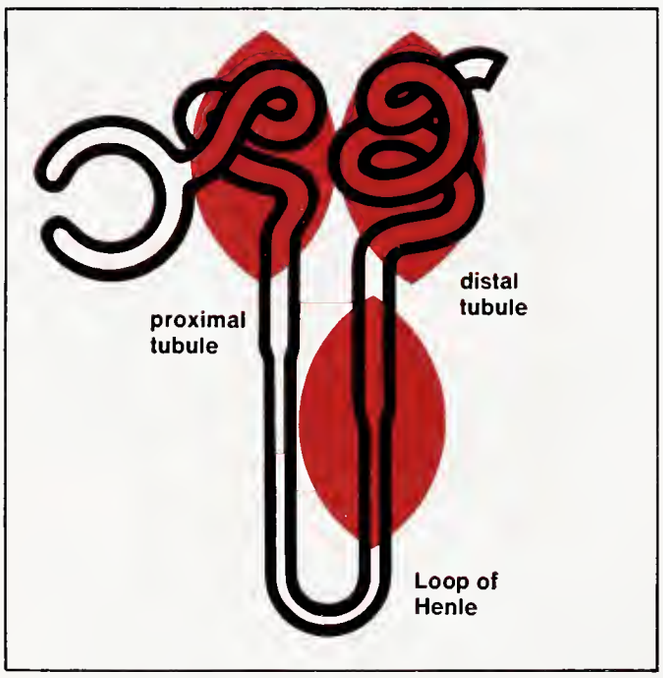

Space photographs courtesy of the
National Aeronautics and Space Administration.

# the new standard for diuretic control

## efficacy

beyond the capacity of any thiazide—outperforms the thiazides by acting throughout the nephron[1,2,3,4]

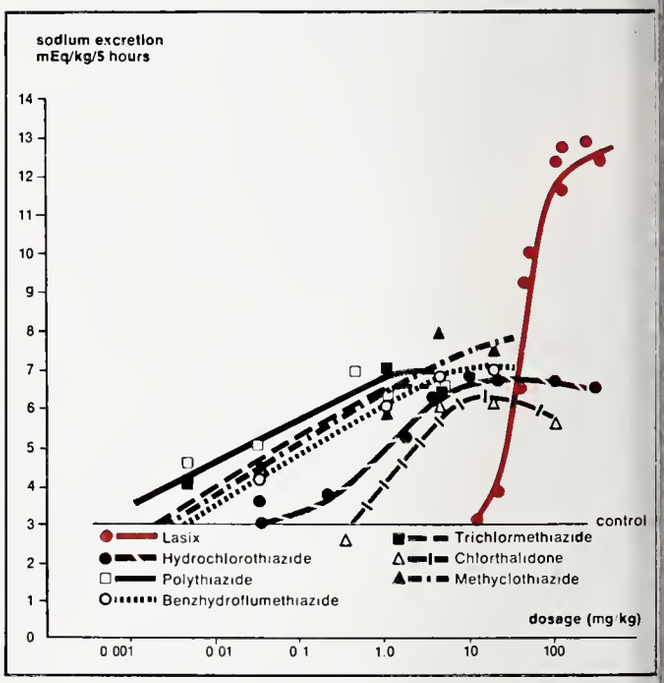
Unlike thiazides, which act only in the proximal and distal tubules, Lasix (furosemide) acts in the loop of Henle, as well as in the proximal and distal tubules




## outstanding control of diuresis

prompt, predictable, dose-regulated action—beyond the ceiling of any thiazide[5,6,7,8]

The natriuretic action of Lasix (furosemide) in rats compared with that of various other diuretics (after Timmerman, *et al.*[5])




## prompt onset, short duration

no more "round-the-clock" diuresis[5,6,7,8,9]

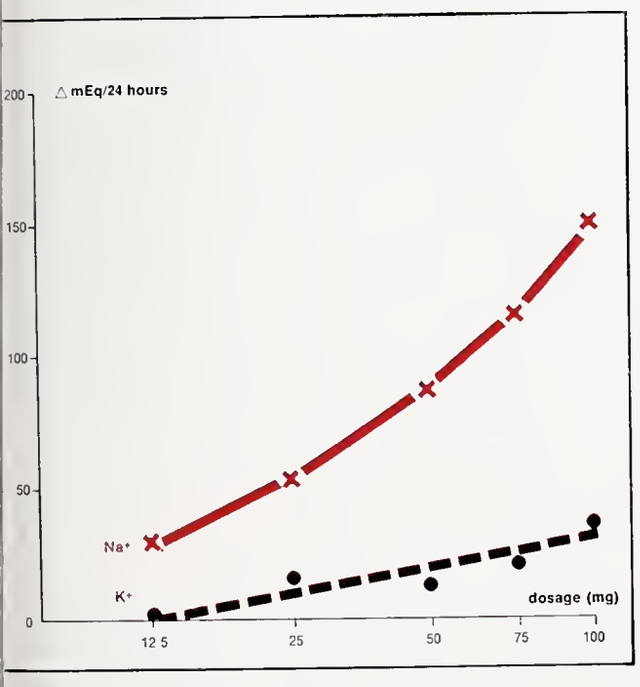
"In our hands, [Lasix] furosemide proved to be a safe and effective diuretic with excellent patient acceptance. Particularly the predictability of response to the drug in terms of its rapid onset and short duration of action enabled us to 'tailor', so to speak, the diuresis to the individual patient's life circumstances. By administering the second dose early in the afternoon, nocturia could be avoided, and the patient assured of a good night's sleep."[9]

# new Lasix®
## furosemide
**a non-thiazide diuretic**

## ighly favorable
## rinary Na/K ratio

reatly enhanced Na, propor-
onately low K excretion[6,7,10]

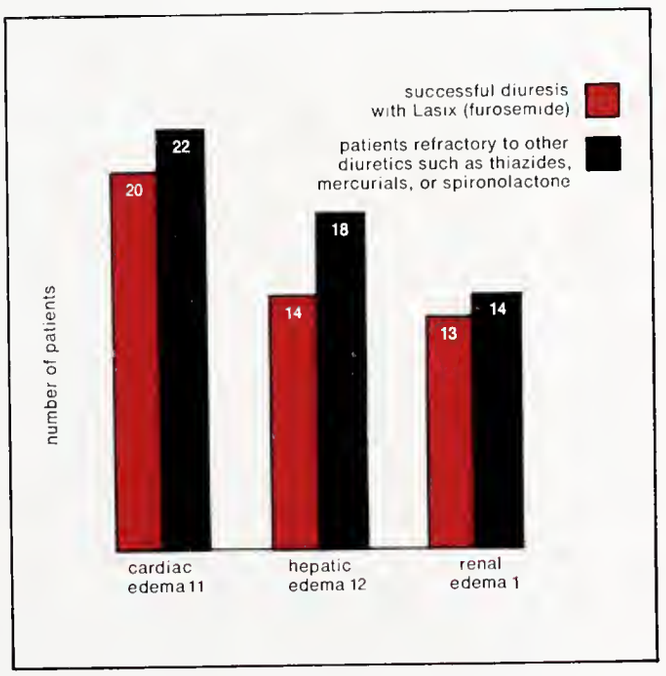
ose-response curve on sodium and potas-
um excretion in normal subjects after oral
dministration of Lasix (furosemide) (after
leinfelder[7])




## useful in a wide range of patients

in cardiac, hepatic, and renal edema, including thiazide-refractory cases[1,11,12]

Response to Lasix (furosemide) in patients refractory to other diuretic agents: results from three studies[1,11,12]




See full prescribing information on following page:

HOECHST PHARMACEUTICALS, INC.

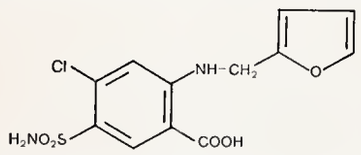
# Lasix®

brand of furosemide

**WARNING—Lasix (furosemide) is a new, potent diuretic, which if given in excessive amounts can lead to a profound diuresis with water and electrolyte depletion. Therefore, careful medical supervision is required and dose and dose schedule have to be adjusted to the individual patient's needs. (See under "Dosage and Administration.")**

Lasix (furosemide) is a new diuretic, chemically distinct from the organomercurials, thiazides and other heterocyclic compounds. It is characterized by: a high degree of efficacy; a rapid onset of action; a comparatively short duration of action; a ratio of minimum to maximum effective dose higher than 1:10; the fact that it acts not only at the proximal and distal tubule but also at the ascending limb of Henle's loop.

**Chemistry**—Lasix (furosemide) is an anthranilic acid derivative. Chemically, it is 4-chloro-N-furfuryl-5-sulfamoylanthranilic acid. The structural formula is as follows:




**Indications**—Lasix (furosemide) is indicated for the treatment of edema associated with congestive heart failure, cirrhosis of the liver, and renal disease, including the nephrotic syndrome. Lasix (furosemide) is particularly useful when an agent with greater diuretic potential than those commonly employed is desired. Until further clinical experience is accumulated, Lasix (furosemide) is not recommended for use in hypertension.

**Dosage and Administration**—The usual dose of Lasix (furosemide) is 1 to 2 tablets (40 to 80 mg) given as a single dose, preferably in the morning. Ordinarily, a prompt diuresis ensues. Depending on the patient's response, a second dose can be administered 6 to 8 hours later. This dosage and dosage schedule can then be maintained or even reduced. If the diuretic response with a single dose of 1 to 2 tablets (40 to 80 mg) is not satisfactory, e.g., in a patient with congestive heart failure refractory to maximal doses of thiazides, the following schedule should be used: Increase this dose by increments of 1 tablet (40 mg) not sooner than 6 to 8 hours after the previous dose until the desired diuretic effect has been obtained. This individually determined single dose should then be given once or twice daily (e.g., at 8:00 a.m. and 2:00 p.m.). Based on completed studies, a maximum daily dose of 200 mg should not be exceeded. Higher doses are currently under investigation. The mobilization of edema may be most efficiently and safely accomplished by utilizing an intermittent dosage schedule in which the diuretic is given for 2 to 4 consecutive days each week. With doses exceeding 80 mg/day and given for prolonged periods, careful clinical and laboratory observations are particularly advisable. Until further experience in children is accumulated, Lasix (furosemide) should not be given to children.

**Contraindications**—Lasix (furosemide) is contraindicated in anuria. If increasing azotemia and oliguria occur during treatment of severe progressive renal disease the drug should be discontinued. In hepatic coma and in states of electrolyte depletion, therapy should not be instituted until the basic condition is improved or corrected. Lasix (furosemide) is contraindicated in patients with a history of hypersensitivity to this compound.

**Supplementary Warnings**—Excessive diuresis may result in dehydration and reduction in blood volume, with circulatory collapse and with the possibility of vascular thrombosis and embolism particularly in elderly patients. Excessive loss of potassium in patients receiving digitalis glycosides may precipitate digitalis toxicity. Care should also be exercised in patients receiving potassium depleting steroids. Frequent serum electrolyte, $CO_2$ and BUN determinations should be performed during the first few months of therapy and periodically thereafter and abnormalities corrected or the drug temporarily withdrawn. **In patients with hepatic cirrhosis and ascites initiation of therapy with Lasix (furosemide) is best carried out in the hospital.** Sudden alterations of fluid and electrolyte balance in patients with cirrhosis may precipitate hepatic coma; therefore, strict observation is necessary during the period of diuresis. Supplemental potassium chloride and, if required, an aldosterone antagonist are helpful in preventing hypokalemia and metabolic alkalosis. As with any new drug, patients should be observed regularly for the possible occurrence of blood dyscrasias, liver damage, or other idiosyncratic reactions. In those instances where potassium supplementation is required, coated potassium tablets should be used only when adequate dietary supplementation is not practical. There have been several reports, published and unpublished, concerning nonspecific small bowel lesions consisting of stenosis with or without ulceration, associated with the administration of enteric-coated thiazides with potassium salts. These lesions may occur with enteric-coated potassium tablets alone or when they are used with non-enteric-coated thiazides, or certain other oral diuretics. These small bowel lesions have caused obstruction, hemorrhage, and perforation. Surgery was frequently required, and deaths have occurred. Based on a large survey of physicians and hospitals, both American and foreign, the incidence of these lesions is low, and a causal relationship in man has not been definitely established. Available information tends to implicate enteric-coated potassium salts although lesions of this type also occur spontaneously. Therefore, coated potassium-containing formulations should be administered only when indicated, and should be discontinued immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur.

**Usage in Pregnancy**—The use of any drug in pregnancy, lactation or in the childbearing age group requires that the potential benefits of the drug be weighed against possible hazards to the mother and child. Reproduction studies with Lasix (furosemide) in mice, rabbits, and rats have produced no evidence of drug-induced fetal abnormalities. However, Lasix (furosemide) has had only limited use in pregnant patients.

**Precautions**—As with any potent diuretic, electrolyte depletion may occur during therapy with Lasix (furosemide), especially in patients receiving higher doses and a restricted salt intake. Electrolyte depletion may manifest itself by weakness, dizziness, lethargy, leg cramps, anorexia, vomiting, and/or mental confusion. In edematous hypertensive patients being treated with antihypertensive agents, care should be taken to reduce the dose of these drugs when Lasix (furosemide) is administered, since Lasix (furosemide) potentiates the hypotensive effect of antihypertensive medications. Asymptomatic hyperuricemia can occur and gout may rarely be precipitated. Reversible elevations of BUN may be seen. These have been observed in association with dehydration which should be avoided, particularly in patients with renal insufficiency. Although no pronounced effect on carbohydrate metabolism has been demonstrated, periodic checks on urine and blood glucose should be made in diabetic patients receiving Lasix (furosemide). Occasional increases in blood glucose have occurred during therapy with Lasix (furosemide). Sulfonamide diuretics have been reported to decrease arterial responsiveness to pressor amines and to enhance the effect of tubocurarine. Great caution should be exercised in administering curare or its derivatives to patients undergoing therapy with Lasix (furosemide), and it is advisable to discontinue Lasix (furosemide) for one week prior to any elective surgery.

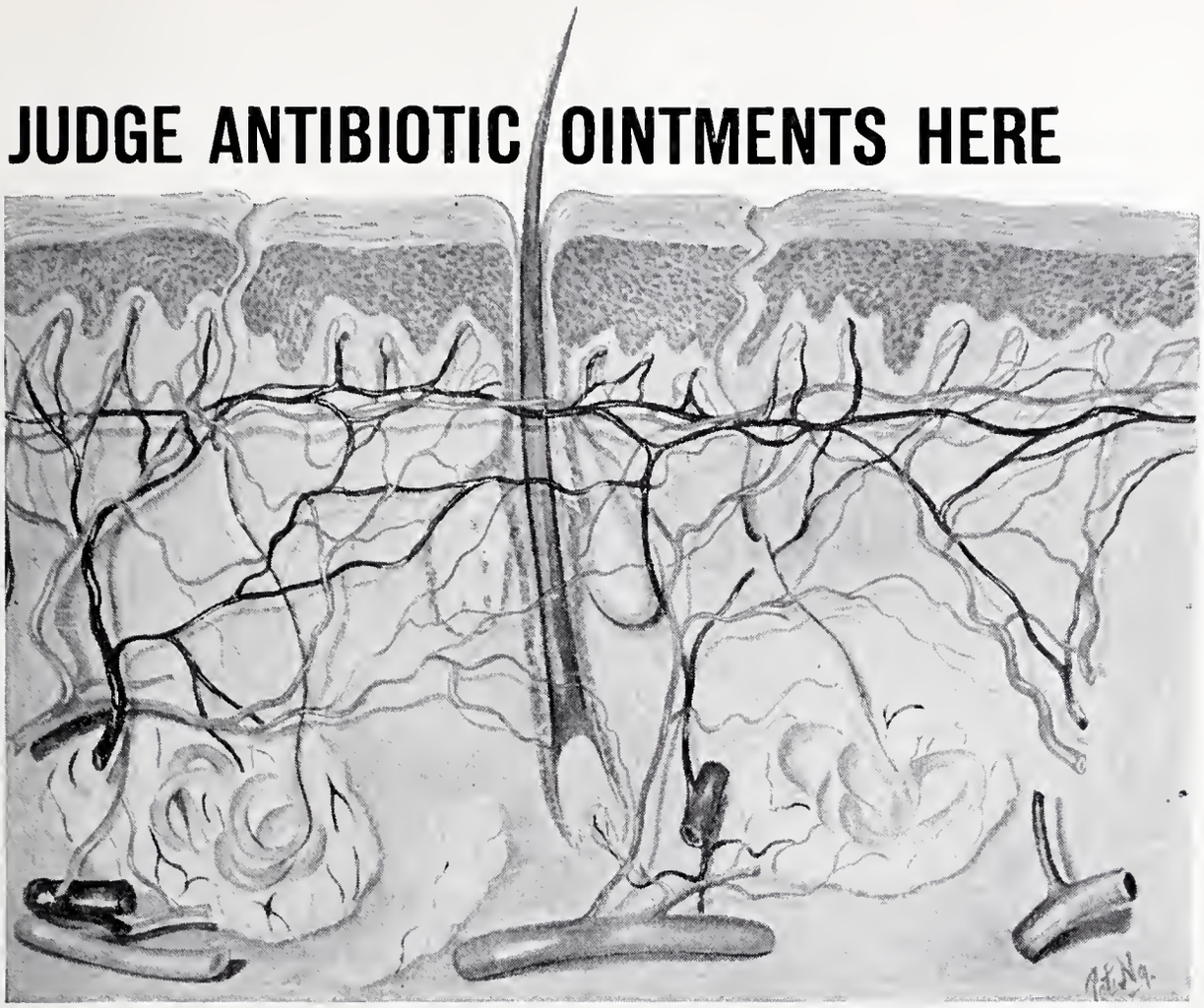
**Adverse Reactions**—Infrequent skin rash, pruritus, paresthesia, blurring of vision, postural hypotension, nausea, vomiting, or diarrhea may occur. A single case of thrombocytopenia has been reported in which Lasix (furosemide) was considered to be the causative agent. There have been a few instances of leukopenia and one report of acute pancreatitis although relationship to the drug has not been established. Lasix (furosemide) induced diuresis has occasionally been accompanied by weakness, fatigue, lightheadedness or dizziness, muscle cramps, thirst, and urinary frequency.

**How Supplied**—Lasix (furosemide) is supplied as white, monogrammed, scored tablets of 40 mg in amber bottles of 100.

**References:** (1) Muth, R. G.: J.A.M.A. *195*: 1066, 1966. (2) Suki, W.; Rector, F. C., Jr., and Seldin, D. W.: J. Clin. Invest. *44*:1458, 1965. (3) Deetjen, P.: Pflüger's Arch. ges. Physiol. *284*:184, 1965. (4) Malnic, G.; Vieira, F. L., and Enokibara, H.: Nature *208*:80, 1965. (5) Timmerman, R. J.; Springman, F. R., and Thoms, R. K.: Current Therap. Res. *6*:88, 1964. (6) Hutcheon, D. E.; Mehta, D., and Romano, A.: Arch. Int. Med. *115*:542, 1965. (7) Kleinfelder, H.: German M. Month. *8*:459, 1963. (8) Stokes, W., and Nunn, L. C. A.: Brit. M. J. *2*:910, 1964. (9) Atkins, L. L.: Geriatrics, in press. (10) Verel, D.; Stentiford, N. H.; Rahman, F., and Saynor, R.: Lancet *2*:1088, 1964. (11) Peltola, P.: Acta med. scandinav. *177*: 777, 1965. (12) Steigmann, F.; Oz, R., and Dubin, A.: Am. J. M. Sc., in press.

HOECHST PHARMACEUTICALS, INC.
FORMERLY LLOYD BROTHERS, INC. • CINCINNATI, OHIO 45229. U.S.A.

# JUDGE ANTIBIOTIC OINTMENTS HERE



## Results on skin are final proof of any topical antibiotic's effectiveness

**No in vitro test can duplicate a clinical situation on living skin.** 'Neosporin' (polymyxin B—bacitracin—neomycin) Ointment has consistently proven its effectiveness in thousands of cases of bacterial skin infection. The spectra of the three antibiotics overlap in such a way as to provide bactericidal action against most pathogenic bacteria likely to be found topically. Diffusion of the antibiotics from the special petrolatum base is rapid since they are insoluble in the petrolatum, but readily soluble in tissue fluids. The Ointment is bland and nonirritating.

**Caution:** As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

**Contraindications:** This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

**Supplied:** Tubes of 1 oz., ½ oz. with applicator tip, and ⅛ oz. with ophthalmic tip.

Complete literature available on request from Professional Services Dept. PML.

# 'NEOSPORIN'®

brand

## POLYMYXIN B-BACITRACIN-NEOMYCIN OINTMENT

**BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.**

ONLY 20 MINUTES FROM
DOWNTOWN HONOLULU . . .

# KAHANAOLA

ON THE GROUNDS OF POHAI NANI RETIREMENT HOME

*Hawaii's most modern convalescent hospital*

- Round the clock care supervised by R.N.'s
- Private and semi-private rooms; 42 beds
- Occupational and physical therapy
- Piped-in oxygen to each bed
- Private 2-way intercom to nurses' station
- Recreation lounge with TV
- Dietary needs supervised by trained dietitian

Refer your patients to Kahanaola for
CARE . . . BY THOSE WHO CARE

*For information, write: Administrator*
**KAHANAOLA CONVALESCENT HOSPITAL**
45-090 Namoku St., Kaneohe, Hawaii • Phones: 241-670 / 246-211



**ENDORSED BY:** American Hospital Assoc. / Hawaii State Nursing Home Assoc. / Hospital Assoc. of Hawaii
American Nursing Home Assoc.

# LIBRIUM®
## (chlordiazepoxide HCl)

ROCHE

# WHEN ANXIETY IS A SIGNIFICANT COMPONENT OF THE CLINICAL PROFILE

Before prescribing, please consult complete product information, a summary of which follows:

**Contraindications:** Patients with known hypersensitivity to the drug.

**Warnings:** Caution patients about possible combined effects with alcohol and other CNS depressants. Warn against hazardous occupations requiring complete mental alertness. Use caution in administering to addiction-prone patients or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of child-bearing age requires that its potential benefits be weighed against its possible hazards.

**Precautions:** In elderly and debilitated and in children over five, limit dosage to smallest effective amount, increasing gradually as needed and tolerated. In general, concomitant use with other psychotropics is not recommended. Paradoxical reactions have been reported in psychiatric patients and hyperactive aggressive children. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically. Observe usual precautions in presence of impaired renal or hepatic function, impending depression and suicidal tendencies.

**Adverse reactions:** Drowsiness, ataxia and confusion may occur, especially in elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. Syncope occurs rarely. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis, jaundice and hepatic dysfunction) may develop occasionally, making periodic blood counts and liver-function tests advisable during protracted therapy. Individual maintenance dosages should be determined.

**Dosage:** Oral—Adults: Mild to moderate anxiety and tension, 5 or 10 mg t.i.d. or q.i.d.; severe states, 20 or 25 mg t.i.d. or q.i.d. Geriatric patients: 5 mg b.i.d. to q.i.d.

**Supplied:** Capsules, 5 mg, 10 mg and 25 mg—bottles of 50.

**Roche Laboratories** • Division of Hoffmann-La Roche Inc • Nutley, N.J. 07110



# IDENTI-CODE™

(formula identification code, Lilly)

## takes the guesswork out of product identification

A special letter-number symbol will appear on each Lilly capsule or tablet. By checking this code against the *Identi-Code Index*, you will be able to identify each unit quickly and accurately:

**In cases of overdosage**

**As a safeguard against error**

**When medication was prescribed by another physician**

**When the prescription label is lost**

**During telephone conversations with patients**

A complete explanation of Identi-Code and its use is provided in the *Identi-Code Index*. If you have not yet received an index, your Lilly representative will be pleased to supply you with a copy.

---

*Representative Lilly Products Bearing Identi-Code*




ELI LILLY AND COMPANY, INDIANAPOLIS, INDIANA 46206 601553 Lilly

*There are many reasons for objecting to abortion.*

*A Catholic physician presents the religious argument.*

# Somebody's Going To Get Killed

WILLIAM N. BERGIN, M.D., *Hilo*

• *Since the soul of an individual comes into existence at the moment of fertilization of the ovum, interruption of pregnancy at any stage compels a soul to "wander the reaches of limbo" eternally. It is considered that this is a sufficient reason for refraining from interruption of any pregnancy whatever, for any reason whatever.*

THE MODERNS are dashing off in all directions demanding easy abortion laws to replace our "archaic" laws.[1] It is about time that somebody spoke up for the little guy that's going to get clobbered.

The barrage is slanted towards the rights of the mother and her doctor. May the little living zygote, who has neither hair, nor teeth, nor tongue to speak with, have the floor for a moment? It's his life that is at stake.

The campaign to eliminate him is well under way in the Islands. Forty-eight-point headlines in our papers declare:

CONTROVERSIAL BISHOP PIKE ASKS PHYSICIANS TO FLOUT ABORTION LAWS.[1]

ISLAND ABORTIONS FEW AND KEPT SECRET.[2]

LEGALIZED ABORTIONS HOLD BIRTH RATE DOWN, JAPAN WHIPS POPULATION EXPLOSION.[3]

ABORTION GROUP FORMED ON COAST.[4]

The abortion problem has been exposed on television and through popular magazines such as the *Saturday Evening Post, Redbook, Look, Life, Newsweek, Time, Good Housekeeping,* and *Parents*.[5]

The stand of the Church of Rome is no different from that of all Christians and Jews. Protestants, Jews, and Catholics accept the Ten Commandments God gave Moses the morning Mount Sinai burned. The Fifth Commandment has not been deleted as yet, Bishop Pike to the contrary. All of us believe that a good end *never* justifies an evil means. Since all abortions snuff out a life, abortion *is* an evil means. It's as simple as that.

The soul is the *'uhane*[6] of the old Hawaiians It comes at the moment of conception and leaves at the moment of death.

At a recent meeting for the Society for Humane Abortions in San Francisco, Mrs. Sherry Finkbone of thalidomide fame said: "I was asked by newspapermen at the time, 'does the fetus have a soul'? I had never thought of it."[7] Is not the human life and soul sufficiently precious that we should *take* a few moments to think of it?

The proponents of abortion say that, "whenever the existing law hinders the conduct of medicine"[8] we should "crush the flowerlet in the bud"[9] and exchange the "imprisoning womb"[9] for the "darker closets of the tomb."[9]

Should the courts decide that physicians have the right to kill or perform fetal euthanasia? We of the medical profession must then decide whom and when to kill. Should we kill the crone, the newborn, the menopausal, or the adolescent?

Only five of the fifty states outlaw capital punishment but the death sentence is rarely imposed in the other forty-five, for fear that among hundreds of guilty, one innocent life might be taken. Jack Ruby murdered Lee Harvey Oswald on television. The nation viewed the act—and yet, look

Received for publication July 26, 1966.

at all the deliberation and delay that he has been accordcd. Do you think for a moment Richard Speck will be accorded any less consideration? Why must we be so casual about the life of an innocent embryo? Why do we consider executing him on the assumption that he "might" produce a threat to his mother's life or well-being or that he "might" be born deformed?

> And wisest clerks have miss'd the mark,
> Why human buds, like this, should fall,
> More brief than fly ephemeral
> That has his day; while shrivell'd crones
> Stiffen with age to stocks and stones . . .[9]

Does life begin at the moment the zygote is formed, at the moment of quickening, or at the time the umbilical cord is tied? Legal,[10] medical, and moral authorities agree and none can disprove that life starts the instant the gametes are joined. The moment life begins, a soul comes to be, and at that second certain activities indicate the presence of life. It is elementary that the moment a spermatozoon penetrates the zona pellucida, it hardens, and the remaining spermatozoa beat their heads in futility against the covering of the egg. At the same moment the chromosomes and genes of both sexes begin their interplay; the maturation process is underway; and the anlagen of all features of the new being are coded. (Just as the answers of a computer are predetermined at the moment that the facts are fed into the maw of the computer.) Within moments the single cell becomes two, then four, then eight, and so on in geometric progression.

These functions are accepted by all authorities as evidence that life exists; and where life exists, a soul exists. Webster's defines the soul as: "An entity conceived as the essence, substance; animating principle or actuating cause of life, or of the individual life, especially of individual life manifested in thinking, willing and knowing."[11] Indeed, no one can disprove the statement that the fetus' life begins the instant that the egg's ectoplasm is punctured by the spermatozoon. At that same instant and site the meridians of front and back, head and tail, right and left are determined.

> And surely we are all out of the computation of our age, and every man is some months elder than he bethinks him; for we live, move, have a being, and are subject to the actions of the elements, and the malice of disease, in that other World, the truest microcosm, the Womb of our Mother.[12]

The absolute and relative medical indications for an abortion are evanescent. At one time tuberculosis was viewed as an absolute indication for abortion. Since the advent of chemotherapy it is no longer so considered. Hyperemesis gravidarum, eclampsia, diabetes, renal and heart disease, and the psychoses of pregnancy have receded as absolute indications. In their place social and eugenic indications have become salient.

At the moment, German measles is being trumpeted as both a maternal (psychological) and fetal indication for the termination of pregnancy. Barbara Prock states "But such abortions on the malformed children may soon belong to the past, for early last month the USPHS announced a vaccine against German measles. It is a medical breakthrough that doctors and mothers-to-be have been eagerly awaiting."[13] A UPI New York release described the work of Paul D. Parkman, Harry M. Nuzer, Jr., Ruth L. Kirschstein, and Hope E. Hopps of the USPHS in attenuating the virus and the successful production of antibodies in mentally retarded children under the supervision of Theodore C. Panos, Professor of Pediatrics of the University of Arkansas Medical School.[14]

A report in the *New England Journal of Medicine* describes his work at one of the University of Arkansas's institutions for mentally retarded children, where 34 children were vaccinated. "None had had German measles according to antibody pretesting. The children lived side by side with other children in an institution cottage. The report showed that none of the nonvaccinated children developed cross-infections and that the vaccinated ones showed antibody responses believed sufficient to protect them just as effectively as though by infection with the wild variety of the virus."[14]

Infection of a mother with German measles may be overt, or may resemble the clinical picture of scarlet fever, ECHO or adenoviruses, or other exanthemata. It is imperative that the diagnosis be substantiated by a rise in the serum antibody titer of the mother, which is accurate even retrospectively, by specific complement fixation tests.[15] One of the largest clinical laboratories in Honolulu informed me that they are prepared to test for antibody titer and to isolate the virus by throat culture. They have had no requests for such a procedure to date. (God only knows how many abortions have been performed for "German measles" without the isolation of the virus or testing for the presence of antibodies to the rubella virus in the mothers' serum.)

Dr. Howard Liljestrand, as reported by Tomi Knaefler, said, "Deformities resulting from German measles in the pregnant mother occur in from 25 percent to 50 percent of the cases." This is in agreement with most studies. Why can't we physicians be truly "humane" and "scientific" about this and let the conceptus go to term and be delivered? Then the one to three normal infants could be sent to the nursery and the deformed put away

"humanely and mercifully" with a drop of potassium cyanide. I am sure the surgeon behind the curette would "chicken out" at the prospect of killing a living creature he could see.

Thanks to the alertness of Frances O. Kelsey, the teratogenicity of drugs has been emphasized, and physicians use all drugs with the greatest of trepidation in the first trimester of pregnancy.

"The Society for Humane Abortions." What a contradiction of terms! Indeed, if a curettage is a humane procedure, then why are we not humanely disposing of our criminals by running over them with a battalion of twenty or thirty D-10 bulldozers? Proportionately this would be a comparatively more humane procedure for killing than the curette.

As to the serious social aspects, especially unwed mothers, the raped, and incestuously impregnated: The unwed mother is indeed a heartbreak for the girl and a horrible cross for her parents to bear. But we are not punishing the right party, we are punishing the innocent embryo. The guilty parties are the boy that made the daughter pregnant and the girl that submitted and even perhaps encouraged him. To quote the Reverend John Beck of Hilo's First United Presbyterian Church, "There are no illegitimate children—only illegitimate parents."

We all know an esteemed matron whose maiden name we would quickly recognize, but whom I will call Maria. Maria became pregnant in high school thirty years ago. Her parents were brave enough to insist she carry her illegitimate pregnancy to term. She spent six of her nine months in a California institute for unwed mothers. Her high school education was completed there and a normal child was born and put out for adoption. Imagine the agony of this whole family at the time! Today, thirty years later, few other than her parents recall the tragedy. Time heals. But think how much happier she is now, knowing that he is a loved and respected man and not a soul she condemned to wander the vast reaches of limbo eternally. I, and many of you, have lived long enough to have observed the evolution of the whole procedure. We can recall girls who became pregnant before high school commencement. In my case, that was forty years ago. Looking at them now, they are respected and honored wives and mothers, and their frailty is forgotten except by the few of us who can recall the immediate tragedy.

We all have "illegitimate" children in our practice and among our acquaintances. Many of them have attained stature and usefulness in our local society. We all know of many Marias. These adolescent peccadilloes are always forgotten, and high and low, in our society, they are not ostracized. Is a pregnant daughter such a tragedy that it calls for a killing?

I cannot imagine anything more horrible than to have one of my daughters raped, particularly by a demented criminal. But how often does true rape occur?[16] Why not execute the guilty party that our society spares? Justice is not served by the killing of the innocent fertilized cell. Perhaps John McLean Morris' "morning after" pill may find valued use in such instances.

Incest, horrible in every time and society of the world, is conducive to deformities and mental deficiency, but incestuous pregnancies are probably rare. There have been but twenty-three convictions for incest in the past ten years in this State[17] and certainly not all resulted in a pregnancy. Here again we are killing the innocent. Deformed and dumb as they are, they have a right to live, and society has the duty to provide for their care.

Dr. Greenhill shows the rapidly increased incidence of therapeutic abortions after relaxation of the abortion laws in the Scandinavian and Balkan countries. Denmark, from 1940 to 1956, had a 700 percent increase, or 49-54 abortions per thousand live births. Sweden, from 1941 to 1956, had a 900 percent increase, or 27-32 abortions per thousand live births. These were legal abortions, though done not only for medical indications but also for eugenic, economic, and sociologic reasons, and for exhaustion neuroses.[18]

"In Chile, 1950 to 1954, for every 100 women admitted to hospitals for delivery about 35 were admitted for legal therapeutic abortions. In Switzerland, recently the rate was one therapeutic abortion for every 15 births."[18]

Greenhill also quotes Muramatsu as follows: "In summary it can be stated that the number of live births in 1955 in Japan would have amounted to twice (or more) the number actually registered, if there had been no induced abortion at all. The reporting of induced abortions through the health authorities probably included 50 percent to 60 percent of the cases actually performed."[18]

"Statistics at the Welfare Ministry of Japan show that there was one abortion for every two births in Japan in 1965. In the 18 years since induced abortion was legalized in Japan under the 'eugenic protection law' the practice has become so commonplace it is taken for granted. Even foreigners flock from abroad to take advantage of its liberal provisions."[19]

Could there be a relationship between "easy abortion laws" and the high incidence of suicide and alcoholism in Japan and the Scandinavian and Balkan countries?

Studies by Russell and Moore[20] showed that in California the incidence of therapeutic abortions is greater in private room patients as compared to ward patients; in private hospitals as compared to county hospitals; and in white as compared to colored. Does the above mean that the poor receive better prenatal care than the well-to-do? Or have stronger constitutions? Or are free of the threats and complications of pregnancy that beset the financially more fortunate? Indeed not! It simply means that the private patient has the necessary pressure and the money to procure an abortion. Lohner showed the low incidence of therapeutic abortion in Salt Lake City to be 1:2482 as compared to 1:160 at Mt. Sinai, New York; 1:214 at the University of Pennsylvania; 1:277 at Tucson and 1:444 at Liverpool Maternity.[21]

Lohner ascribes the low incidence to the strong religious atmosphere in Utah, since the theology of the L. D. S. Church places great value on having children.

Legalization would reduce the number of criminal abortions and increase the number of abortions in accredited hospitals, but is our concern only "for the transfer of the execution chamber to more aseptic conditions?"[22]

We could readily eliminate "murder" in our country if we simply legalized the act.

Dr. Alan F. Guttmacher, a thoughtful and outstanding authority, has proposed that instead of the single consultation required by the accreditation board, a committee of at least five be established to whom written requests for an abortion would be submitted.[23] They would study and approve or reject the request. This I believe is pretty good, but it has one fault: The unborn child has no representation. Since he is going to be executed, shouldn't a defender of the fetus be included? Possibly a Catholic physician, a priest, or an outstanding Catholic layman? In this way, at the very least a minority report could be rendered. With this amendment I would feel that Dr. Guttmacher's suggestion would at least be fair. Let's be honest about things: without this, the group would be picked and stacked against the embryo and the plan would be subjected to the same abuse it has received in many hospitals where the committee of department chiefs, social workers, and others concerned, do not even bother to amplify or to give their reasons. They simply write "I concur" and sign their name. This has relegated Dr. Guttmacher's honest and excellent proposals to the level of western justice: the fetus is given a fair trial before being executed!

Woman, bless her, is the loveliest of God's creatures, marveled at and praised by poets and painters throughout the ages. Indeed she is a lovely flower and jewel, a joy and comfort to her spouse and a loved and revered mother. This lovely and delicate flower, never for a moment out of our masculine minds, presents handling problems. She is not always rational and from the day of her birth is couched in deceit. When she finds herself with a child she has not planned on, she often becomes upset. Even the finest of women feel put upon at times during their pregnancy, even though they welcome the pregnancy, until they can adjust to the idea that the child is on the way. A woman often willingly or subconsciously will use her faculties of deceit to get out of the fix she finds herself in. She may threaten suicide but rarely does she carry it out (practically never).[24]. Nor does she go to the family physician and ask for an abortion—that is passé. She knows his answer. How easy it would be for her to attend a German measles party for pregnant women or to trump up an excuse for her physician to give her a teratogenic drug such as tetracycline! Then she could present herself to her obstetrician with a built-in legitimate indication for a therapeutic abortion.

Let us not kid ourselves. We all know that abortions are performed by respected men occasionally and in respected hospitals under one guise or another. This is done even in Catholic hospitals. Hardly a month after I had completed my internship I was called on an emergency consultation to St. Francis Hospital. The physician requesting the consultation did not tell me that the patient was pregnant but urged my immediate presence for "a hemorrhage case." On my arrival I found a young lady in her early twenties on a Gurney just outside the operating suite, already prepped and bleeding vaginally, with obvious products of conception presenting. Puzzled and green and confronted with an inevitable abortion, I gave approval and hardly a moment later she was ushered into the operating room and put in stirrups. The requesting physician (who subsequently lost his license because of narcotic violations and was reputed a wholesale abortionist) later told me, "Billy, this was easy. I simply inserted a sound in my office and waited until the bleeding began and rushed her to St. Francis for an emergency D and C." What could the nuns say? It was then an "abortion in progress" and justified.

By the grace of God, the incidence of abortions is extremely low here in the Islands, which speaks highly for the medical profession; but we do know of instances where, for a few moments, eyes are closed and an improper termination of pregnancy is performed.

The psychic trauma that a woman suffers following an abortion is often severe. This feeling of guilt and its attendant anxiety accompanies the aborted the rest of her life and she is haunted to her grave by the thought of the wandering soul whose innocent life she took. To most women, particularly Catholics, this is an extremely traumatic experience, and they can never put out of their minds the image of their cherub in limbo. This guilt syndrome occurs frequently among Catholics who have been sterilized. A vasectomized male feels inadequate; as the Hawaiians say, *Lahu ole*. Men often feel guilty of having deliberately eunuchized themselves. (A few years ago when vasectomies were so popular here in the Islands, I did a rather thriving business reapproximating vasa according to the technique of Vincent O'Connor of Chicago. I had no failures, if the presence of live motive sperm in the semen is considered evidence of success; but the true success of the operation was the peace of mind that returned along with his fertility.)

I recently attended the wedding of a lovely girl, a college graduate. Well do I remember her mother's tempestuous pregnancy with multiple indications for therapeutic abortion presenting. Don't think my heart didn't swell when the bells of St. Joseph's pealed. Another mother spent four months in Laupahoehoe Hospital on absolute bed rest, bleeding throughout the time. Under local anesthesia she was delivered by Caesarian section. The child she bore now teaches history in one of our high schools.

I speak not without background; in my time I have conducted nearly 2500 accouchements. I have never knowingly interrupted a pregnancy nor have I felt that any woman or child suffered at my hands because of my mores.

## L'ENVOI

*The Diary Of An Unborn Child*

*October 5:* Today my life began. My parents do not know it yet. I am as small as an apple seed, but it is already I. The whole big world cannot say I, but I can.

*October 19:* I have grown a little, but I am still too small to do anything by myself. My mother does just about everything for me. Some say that I am not a real person yet, that only my mother exists. But I am a real person, just as a small crumb of bread is truly bread. My mother is. And I am.

*November 2:* I am growing a bit every day. My arms and legs are beginning to take shape. Even if I were to be born deformed, without arms and legs, I could have artificial ones, as grown people sometimes have—and even at the worst, I would be I, ready to have water poured on my head so that I can see God.

*November 20:* It wasn't until today that the doctor told Mom that I am living here under her heart. She is helping me already; she is even feeding me with her own blood. She is so good.

*December 10:* My hair is growing. It is smooth and bright and shiny. I wonder what kind of hair Mom has?

*December 13:* I am just about able to see. It is dark around me. When Mom brings me into the world, it will be full of sunshine and flowers. I have never seen a flower. But what I want more than anything is to see my Mom. How do you look, Mom?

*December 24:* (Christmas Eve) I wonder if Mom hears the whispering beat of my heart? Some children come into the world a little sick and then the delicate hands of the doctor perform miracles to bring them to health. But my heart is strong and healthy. You'll have a healthy little girl, Mom!

*December 28:* (Feast of the Holy Innocents) Today, my mother killed me.

## CONCLUSION

1. The fetal mortality from abortions is 100 percent.
2. A good end NEVER justifies an evil means.
3. The Fifth Commandment remains immutable and no measure of clerical codology can alter it. ■

305 Wailuku Drive

## REFERENCES


1. Knaefler, T.: Hon. Star-Bul., B3, (May 20) 1966.
2. Hunter, G.: Abortion in the Islands, Hon. Adv., A16, (Apr. 21) 1966.
3. Hon. Star-Bul., B1, (Aug. 10) 1965.
4. U.P.I.: Hon. Adv., A8, (June 16) 1966.
5. Readers Guide to Periodical Literature: (March) 1965 to (Feb.) 1966.
6. Pukui, Mary K., and Elbert, Samuel H.: English-Hawaiian Dictionary, University of Hawaii Press (page 145), 1964.
7. Harrington, Rt. Rev. Msgr. P. V., J.C.L.: Linacre Quarterly: 33 (page 165), (May) 1966.
8. American Medical Association News: (page 1), (Sept. 5) 1966.
9. Lamb, C.: Complete Works and Letters of Charles Lamb, New York, The Modern Library (page 534). Random House, 1935.
10. Sorrentino, John M.: The Law Relating to Prenatal Injuries. Medicolegal Law Dept., American Medical Association (page 9). Justice Proctor, Superior Court of New Jersey: Sinkler vs. Kneale, 401 Pa. 267, 164 A. 2d, 1960.
11. Webster's New Collegiate Dictionary: 2d Ed, G. M. C. Merrian, Springfield, Mass.
12. Hamilton, W. J., Boyd, J. D., Mossman, H. W.: Human Embryology (frontispiece): quoting Sir Thomas Brown. Religio Medici, 1642. Williams and Wilkins, Baltimore, 1952.
13. Prock, Barbara: Sunday Star-Bul. and Adv., D17, (July 3) 1966.
14. U.P.I.: Hon. Star-Bul., D11, (Sept. 22) 1966.
15. Conn, Clohecy, Conn: Current Diagnosis (page 14). W. B. Saunders Co., 1966.
16. DeMello, J.: Hilo Police Department, County of Hawaii, Retired Personal Communication.
17. Wong, W. A.: State of Hawaii, Dept. of Attorney General, Bureau of Statistics and Identification, Personal Communication.
18. Greenhill, J. P.: Clinical Obstetrics and Gynecology, Vol. 7:1. Hoeber Medical Division (pages 37-40), (Mar.) 1964, New York.
19. Yamaguchi, Masatochi: Hon. Adv., A8, (June 21) 1966.
20. Russell, K. P., and Moore, J. C.: Clinical Obstetrics and Gynecology, #1 Hoeber Medical Division, Vol. 7 (pages 43-44). Harper and Row, (Mar.) 1964, N. Y.
21. Lohner, R. W.: Obstetrics and Gynecology (page 665), (May) 1966.
22. McCormick, Rev. R. A., S.J.: America (page 880), (June 19) 1965.
23. Savel, L. E.: Clinical Obstetrics and Gynecology, #1 Hoeber Medical Division, Vol. 7 (pages 16-20). Harper and Row, (Mar.) 1964.
24. Simon, Alexander: Psychiatric Indications for Therapeutic Abortions and Sterilizations, Clinical Obstetrics and Gynecology, #1 Hoeber Medical Division, Vol. 7 (page 74), (Mar.) 1964.

*Though fertility was promoted without stint in ancient China, methods of limiting population growth date back nearly 5000 years.*

# Early Fertility-Management Concepts in China

AMRIT LAL, Ph.M., M.A. (Eco), L.M.S.H., *Delhi, India*

• *Ancient Chinese tradition is strongly in favor of unlimited fertility and large families; both philosophical and governmental edicts attest to this over a period of many centuries. Nevertheless abortions were written of in China nearly 5,000 years ago, and there are references since then to preparations used for either contraception or abortion. Modern birth control methods, advocated out of fear of the effects of overpopulation, have been advocated in some quarters since 1920 or so, but have found little acceptance until the past three decades.*

FERTILITY management concepts have played a minor role in the cultures of the Orient, compared with the Western cultures. It has been a tiring affair for research workers to gather evidence on such concepts in Oriental culture. Histories of Chinese medicine in the English language are particularly wanting in the treatment of the subject, as if these practices, really of considerable medical interest and importance, were nonexistent.

## FERTILITY PRIZED IN CHINA

The Chinese classics also, as a rule, contain only oblique references, or none, to such concepts. The cardinal principle of Confucian way of life, so dear to the Chinese before communism, explicitly states that "to have no posterity is the gravest of unfilial acts." The rumblings of this logic are also perceptible in many other proverbs attributed to great thinkers of China, to wit:

> Give early birth to an heir.
> Rear children for protection in old age.
> More children, more happiness.
> Grain is stored against famine; children are brought up for old age.
>
> FOURTH CENTURY B.C.

Chinese philosophers such as Mo Ti and Mencius spoke in favor of large families. Mo Ti encouraged early marriage to enable an average family to raise a large number of children. Mencius was specifically asked by the monarch of the day to make suggestions for the increase of population of his kingdom.

Another legend states that when Yueh was defeated by Wu in 495 B.C., King Kou Chien of Yueh retreated to Kweichi and encouraged population growth by punishing the parents "if girls of 17 years and boys of 20 years of age and over were not married."

The first written document on the subject is from the Chin dynasty, 281 A.D., wherein the

Received for publication July 6, 1965.

reigning monarch ordained, "If the parents of the girl reaching the age of 14 fail to marry her off, a government official should handle her marriage." An Imperial edict of the reign of Emperor Kaiyuan of the Tang dynasty, 742 A.D. to 756 A.D., added, "Boys over 15 years and girls over 13 years have the right to marry according to law." The age limit was raised to 16 and 14 for boys and girls respectively, according to the statute of the Emperor Hung-wu of the Ming Dynasty, 1368 A.D. to 1644 A.D. The Civil Code of the Kuomintang Government, 1912 to 1949, in the 980th clause, further raised the legal minimum age for marriage to 18 years for boys and 16 years for girls, with the provision "minors who wish to marry must obtain the consent of their guardians."

Values and mores such as these have stuck permanently to the Chinese mind, schooled in the Confucian ideals. Filial piety has been thus firmly entrenched in China's culture so as to provide ancestor worshippers and to serve as the ancient equivalent of old age insurance. Desiring to insure their posterity, married couples pray to the Goddess of Mercy, Kuan-yin, and "make pilgrimages and pass the night on the sacred soil of her temple to draw its life force. In these pilgrimages, magic talismans are brought home to decorate the conjugal bed to bring down the blessing of heaven and ensure numerous children."[1]

## EARLY FERTILITY LIMITATION

Nonetheless, scattered in the various Chinese classics on medicine and other subjects are suggestions that the story of fertility management in China is not as blank as some sinologists would like us to believe. Several old Chinese texts specifically refer to the prevalence of fertility management practices. The earliest mention of such practices is supposed to have been made in the most ancient medical work in the Chinese language, "Shen Nung pen ts'ao Ching," written about 2737-2696 B.C. This classic contains a prescription on abortion, suggesting that the Chinese were commonly practicing abortion in the pre-Christian era.

A familiar Chinese herbal written by T'ang Shen-wei about 1108 B.C. quotes another ancient formula on abortion under the heading Shui yin or mercury:

> Shui yin tastes bitter . . . and contains poison. It is specific in ulcers, white itching sores on the scalp, will kill parasitical worms in the skin and flesh, cause abortion, and cure fevers. . . .

The next reference, historically, to fertility management practices exists in "Ch'ien Chin fang" by Sun Ssu-mo (died A.D. 695). His works under the following titles are suggestive of the contents:

1. Ch'ien Chin tuan fan or Thousands of Gold Contraceptive Prescriptions
2. Ch'ien Chin Ch'u t'ai or Thousands of Gold Prescriptions for Abortions.

Prescriptions mentioned in these works consist of barley, leaven, rape seeds, quicksilver, and a pharmaeological formula comprising varying quantities of Angelica polymorpha, Paconia albiflora, and Conioselnium univittatum.

A work by Hang Mai of the Sung dynasty, 996-1103 A.D., "I Chien Chih," contains references of a large number of prescriptions to secure abortions, but cautions,

> They may only be used in one out of ten thousand cases; therefore, those who use them should do so with caution.

Similarly, a work by Wu Chih Wang was published in 1728 under the title "Chi yin kang mu" or "A Treatise on Gynecology and Obstetries," with a subheading, "Fu tuan tzu fa" or "Supplement on Methods of Contraception." Herein is mentioned the use of a leaven, called mien chiu, to ensure sterility, with the assurance,

> The menstruation will then follow and for the rest of her life she will be without children.

## ECONOMIC PRESSURES

Set alongside these ancient fertility management practices is the economic rationalization for the need of fertility control even as early as three centuries B.C. The following passages are quoted in full because of their grotesque application on the subject:

> In ancient times people were few, but wealthy and without strife; the government gave no rewards or punishments, because people were self-controlled. People at present think that five sons are not much, and each has five sons. Therefore, people are more and wealth is less; they work hard and receive little. The wealth of a nation depends upon people having enough food, not upon the number of people. (Han Fei Tzu, third century B.C.)[2]

> To feed a family of five a farmer must work like an animal. But to feed a family of six even a flogged animal will not work. (An old Shansi Proverb).

Unorthodox protests such as these, exhibiting uneasiness about the population growth's outstripping the means of sustenance, have been made at various times in the course of China's social history. We can discover a few distinct phases in the evolution of fertility management concepts in precommunist China. In the first phase, which

ends with the close of the 18th Century, fertility management concepts enjoyed currency in a loose and disjointed fashion; barring a few exceptions, no attempt was made to propagate them in the community. Contraceptive recipes and abortifacients were largely used on an individual basis. Society, in general, disapproved such practices.

In the second phase, which began with the 19th century, fertility management concepts came to be favored on quasi-Malthusian grounds. Various events of the period anticipated the onset of a more concerted movement shortly afterward. One Hung Liang-Chi, bears the arresting title of the "Chinese Malthus," for he lived about the time of Malthus (1746-1809). In his writings, Hung warned of the inexorable danger of overpopulation. As compiled by Bary[3] *et al,* Hung's generalizations of the principle of a geometric increase in population outstripping a more slowly developing food production, his ideas about the survival of the fittest in the struggle for existence, and finally his reliance on the natural checks are purely Darwinian in essence and Malthusian in conception. His essays echo with the tone of pessimism typical of Malthus:

> Population in thirty years increases five times and ten times in sixty years. Within a matter of a hundred years it will have increased twenty-fold. Even so . . . , the increase in land and houses will be just double, three times or at the most five times the original, whereas the population has increased ten or twenty times . . . Flood and drought, plague and pestilence, are what nature offers as remedies, though the percentage that dies in natural calamities rarely exceeds one- or two-tenths of the population. To distribute one man's food among ten men means deprivation, and that a hundred! . . . There are ten times more farmers than there were, with no increase in land. There are ten times the merchants before, with no increase in the number of jobs for teachers. . . . The income is small and the prices are higher.
>
> (CAUSERIE ON A PEACEFUL REIGN)

About the time that Malthus's philosophy was gaining credence in the West, Hung's ideas were given momentum by two great events in China. The first was the revolution of 1911, with the overthrow of the Manchu regime. The second was the "Movement of May 4, 1919," and the consequent "Women's Movement" which attacked the traditional structure of Chinese Society. In his memorial to Marquis Li Hung-chang towards the close of the Manchu dynasty, Dr. Sun Yat Sen said, in effect:

> China is now overpopulated, as in government offices no vacancies can be found, and as to the general population, a large number of people obtain no employment.[4]

FEMALE EMANCIPATION

At that formative stage in the development of fertility management ideas, the movement assumed essentially a psychological character, and became in part an aggressive attempt to emancipate the "Eve" from the yokes of gestation and lactation. Sociologists, economists, and medical men spoke against the old order, from their respective viewpoints. This gave rise to a spate of articles in the popular press and in technical periodicals as well. For example, an author wrote in 1920:

> Births must be balanced with resources; only then can eugenic progress be achieved, as heralded by modern science. Only scientific, systematic, and energetic restrictions of births will deliver humanity from ills which afflict it, and will produce healthy and active human beings, increasing the general welfare.[5]

MODERN BIRTH CONTROL

Two years later, Margaret Sanger, an American nurse, well known for her crusade against imprudent parenthood, launched a vigorous campaign in favor of fertility management. She found both supporters[6] and criticizers for her venture. Perhaps her campaign was too early, in a land which harbored centuries-old hostility against any artificial means of preventing a life from coming into being.[7]

Among the men who were to have a great say in the affairs of the Chinese state under communism after 1949, Shao Li-tzu spoke in favor of fertility management in extravagant terms. In a series of articles in 1924 in the "Democratic Daily," which he edited, he forewarned:

Chinese Sources Quoted in the Text

| | |
|---|---|
| Chung-kou fu-nu ping-lun | 中國女子女 |
| Chi yin kang mu | 淫陰綱目 |
| Ch'ien chin tuan fang | 千金迷斤方 |
| Ch'ien chin Ch'u t'ai | 千金去胎 |
| Min Chu jih pao | 民主日幸报 |
| Fu Nu tsa-chih | 女子女杂住志 |
| Fu tuan tzu Fa | 阝付迷阝子法 |
| I Chien Chih | 勇敢之志 |
| Shen Nung pen ts'ao Ching | 示申農本草糸至 |

> Unless the art of diminishing the number of births, which our students learned in the West, brings some order into the situation . . . the number of Chinese will continue to grow, and the fear of Malthus will become a reality. The day will come when human beings will be so numerous that there will not be enough to eat for all. Who can say what evils will arise then?[8]

In the same vein Chen Ta, a professional demographer, emphasized the extreme seriousness of the problem:

> Only when China learns the means of voluntary limitation of births will she be able to create desirable conditions of life for the people. . . . It is estimated that half the births in China are unwanted. As a result, half of the newborn children are deprived of elementary care . . . By reason of her inopportune pregnancies, the mother becomes incapable of giving the children the care and attention they need. To remedy this state of affairs, there is only one method: the parents must only have children they want and are capable of giving a good upbringing.[9]

## ABORTION-INFANTICIDE

At a time when Margaret Sanger, Shao Li-tzu, Chen Ta, and many other were preparing soil for the "fertilization" of fertility-management ideology, defenders of the old tradition were not lacking. An article in the popular press, for example, deplored the new movement in these words:

> The old established morality which forbids onanism as well as infanticide and abortion are perfectly logical. The new morality only takes love into account in the union of men and women, and allows such practices which are capable of satisfying this love, even if they deliberately cause sterility. The supporters of this new morality are completely egoists. Their theories are anti-social, for they hinder the increase in population without improving its quality.[10]

In the New Chinese Criminal Code (1928), Articles 332 to 338 dealt exclusively with the problem of abortion and provided penal servitude for abortionists and abortees. However, the law was not enforced with any seriousness and the practice of abortion remained operative with full ferocity:

> Unfortunately the code is not in anything like general use, and there is very little attempt to restrict what in some parts of the country and especially in large cities has become a serious manace and is practiced by many who have no idea of terrible risks involved in their process.[11]

Cormack[12] (1926), in a paper read at the Obstetrical Section of the Biennial Conference of the Chinese Medical Association, also gave a hint of the large number of requests made to doctors in China for securing abortions. In the paper he discussed various methods of contraception. Pointing to the growing awareness of the problem of population, he maintained:

> China with its dense population, immense birth rate, and high infant mortality rate, is in special need of clear guidance of [*sic*] this subject from national, domestic, and economic points of view. Young China, which is so articulate, has already got to discussing this and cognate matters in some public meetings, and has ventured to print in some magazines, articles discussing these subjects.

About the same time a sociologist from Shanghai also confirmed the rising interest among the Chinese in fertility management idcology:

> For some time, articles on birth control have appeared in some of the magazines of China.[13]

## THE MODERN PHASE

Thus, this phase in the evolution of ideas on fertility management, which continued up to the beginning of 1930, consisted of government apathy and a battle of wits between the supporters of "new morality," who argued their case on "Malthusian" grounds and the "vice and misery" consequent upon overpopulation, and the defenders of the "old traditions" who put forward their pro-natalist claims based on Chinese reverence for human life. The obstacles which impeded the growth of the movement at this time were the high prices of contraceptives and their comparatively limited availability, restricted to a few coastal towns. Secondly, fertility management concepts attracted only the upper and upper-middle strata of society.

The real beginning of the fertility management movement may be said to have taken place in February, 1930, when the Peiping Committee on Maternal Health was founded.[14] The Committee was under the leadership of Mr. Maxwell, of the Department of Sociology and Social Work, Yenching University, with the support of Dr. Marian Yang and other medical and social workers. Members of government organs, and of the Peking and Shanghai municipalities, belonged to it in their private capacity. Doctors, intellectuals, and professors at Tsinghua University, Yenching University, and Peking Union Medical College took part in the committee, which took a serious view of overpopulation in hindering popular education and public medical care.

From now onward the ideas became more scientific, and above all, came to be advocated on the basis conventional demographic and economic variables. The first clinic in China to disseminate fertility management concepts, opened in 1935,[15] was conducted in collaboration with the first Red Cross Hospital, where the visiting gynecologist, Dr. Amos Wang, used to devote some time to the work.

But then the corrosion of the framework started. Civil war between the Kuomintang and the Communists, war with Japan, and the Second World War were such urgent propositions for the nation that they monopolized the attention of the government and the masses alike, and the campaign, still in its teens, was a sad casualty. It was only in 1949, when the Communists had eventually succeeded on the mainland, that the possibility of reviving the fertility management campaign came to light in government circles. The post-1949 developments in the evolution of fertility management concepts form an interesting subject of study, though these are beyond the limited scope of this paper.[16] ■

B—1/24 Model Town
Delhi, 9, India

REFERENCES

1. *Dossiers de la Commission Synodale,* Peking, 1935.
2. cf. Cressey, George B.: *Land of 500 Million*—A Geography of China 1955.
3. DeBary, William T., Jr., *Sources of Chinese Tradition* 1960
4. Hua Han Min (ed.) *Complete Works of Sun Yat Sen,* 1930.
5. *Fu Nu tso-Chih* (Women Journal), vol. 6, no. 12.
6. *Fu-nu Tsa-chih* (Woman Journal), vol. 8, no. 6.
7. *Chung kou fu-nu ping-lun* (Chinese Women Journal), May 10, 1922.
8. *Democratic Daily,* June 19, 1924.
9. Chen Ta: *Birth Control is Necessary in China,* Peking 1924.
10. *Sun t'ien Shih-pao,* Peking, April-May, 1920.
11. Maxwell, J. Preston, (1928). On Criminal Abortion in China, *Chinese Medical Journal,* XLII (1).
12. Cormack, J. G., (1926). Contraception or Birth Control. *Chinese Medical Journal,* KL (10).
13. Lamson, H. D., (1930). Educated Women and Birth Control in China. *Chinese Medical Journal,* XLIV, (11).
14. *Chinese Medical Journal,* 1934, p. 786.
15. *Chinese Medical Journal,* May, 1936.
16. For post-1949 developments, read by this author "Fertility Management and Concern with Overpopulation in Mainland China," *Eugenics Quarterly,* New York (September, 1964), 'Fertility Control in Communist China," *Indian Medical Journal,* Calcutta (February, 1965, Editorial), P. T. D.

# LOOPUS BENIGNUS
## or
## The Sperm That Turned

PARK J. WHITE, M.D.
St. Louis, Missouri

Two things, each called Device:
O, may the first suffice
To keep our population from exploding!
For it's the I. U. D.
(That's Intra-uterine,—see?)
A smooth and plastic spiral, non-corroding.

O Browning and your dance
Of plastic circumstance!—
You wrote without Planned Parenthood in mind!
But cheer! No sperm can troop
Nor swarm up past the Loop.
(Let one meet Egg, is Fetus far behind?)

Man's other New Device
Is not by half so nice:
It cuts us down; it's Fission-Fusion Doom!
Let's use more sane defenses;
Let's thwart the spiraling census
And show the womb is mightier than the tomb!

* Reprinted with permission from the *New England Journal of Medicine,* August 4, 1966, Vol. 275, No. 5.

*A long-time employee of the California Medical Association foresees tumultuous times for the practice of medicine.*

# The Relative Value Studies: Fixed Conversion vs. Customary Fees

ROBERT L. THOMAS, *San Francisco*

• *Health care legislation, technological advances, increases in biological knowledge, better health and increasing longevity of people, changing patterns of professional activity, and changes in the structure and function of medical institutions are among the factors involved in the changes occurring in the character of the practice of medicine.*

AS THE effectiveness of medicine increases, medical care is being considered by many people more and more to be a basic right of everyone and the concept of "separate but equal" is recognized as unsound.

The effectiveness and economy of medical services, both in manpower and in costs, are increasingly recognized as a concern of the *public,* as well as of the physician and the patient.

## GOVERNMENT REGULATIONS

Within the framework of federal and state health care legislation passed in the last two years, government has *generally* left "the delivery of medical care" alone. P.L. 89-239, the Heart Disease, Cancer and Stroke legislation, promises to accomplish its ends "without interfering with the patterns, or the methods of financing of patient care or of professional practice, or with the administration of hospitals." P.L. 89-97, the Medicare Law, goes a step further by promising that no federal official shall be permitted "to exercise any supervision or control over the practice of medicine or the manner in which the services are provided."

These are fine, well intended phrases; but what about impact, regulations, corresponding changes in attitudes and direction?

Permit me to quote from an April 18, 1966, memorandum prepared by the Surgeon General of the United States Public Health Service to the Secretary of the Department of Health, Education and Welfare; the subjeet: "Reorganization of the Public Health Service:"

> . . . . . I feel that the time is now ripe for a definitive statement of our aims and the organizational structure which will, in my judgment, serve them best. This memorandum is designed to constitute such a statement.
>
> My fundamental thesis is that the health of the American people, *in its totality,* shall be the overriding concern of the Public Health Service and the measure of our success or failure. Our ultimate commitment is not to agencies or institutions, but to people. In this context the Surgeon General should be the individual to whom the public may turn when their expectations for health care are not being fulfilled.
>
> The Service would welcome this assumption of central responsibility for health on behalf of the people.

The memo continues to describe a proposed organizational plan consisting of eight major components, as follows:

Read before the Western Conference of Foundations for Medical Care, Honolulu, June 21, 1966.

Bureau of Health Services
Bureau of Health Manpower
Bureau of Disease and Injury
Prevention and Control
National Institutes of Health
National Institute of Mental Health

and, reporting directly to the Office of the Surgeon General, the National Library of Medicine and the National Center for Health Statistics.

The memo continues:

> The rapid growth of Federal involvement in health affairs has made our present organizational structure obsolete and dictated the need for reorientation. There is every reason to expect that this involvement will continue to grow and diversify. Therefore, any structure must be adaptable to change . . . . .

Does this memo spotlight a "stage door Johnnie" or a "stand-in" waiting in the wings of the public stage?

### THE HOSPITAL

Let's examine more closely some of the changes and choices being brought about by these pressures and effects of regulations in view of our concern for high quality care, the continuation of prepaid medical care insurance, our concern over methods of physician remuneration, and our need to strengthen and maintain the tools, mechanisms, and techniques now available to the medical profession.

P.L. 89-97 has embodied in it concepts which may have a profound impact on the practice of medicine, the insurance industry and the methods of physician compensation.

In broad terms, this law establishes the hospital as the center of medical care for the community. It establishes methods by which standards of care can be enforced and quality of care evaluated and judged. It provides standardized definitions which now serve as a national mode of communication, for example, extended care facility, utilization review, prevailing charges, transfer agreement, and home health services, to mention only a few.

P.L. 89-97 establishes the premise of high level, centralized policy, leaving implementation to those who provide the care, yet establishing a secondary level of supervision to make sure various stipulated criteria are met by the providers. It plaees within the realm of reality, for 15 to 20 per cent of the population, the meaning of many of the relatively new phrases and words in the medical and health planning voeabulary, such as, "broad spectrum of services," "continuity of care," "progressive care," "home care," "mainstream care" and "comprehensive care."

Fragmentation of practitioners into more specialties and subspecialties may be promoted by the Heart, Cancer and Stroke Program. At the same time, general practitioners, internists, and surgeons will reeeive the bulk of the increase in home, office, nursing home, and hospital care under P.L. 89-97. Ophthalmologists and urologists will also feel the impact of this newly released demand for services. Paramedical personnel will begin to face new and more demanding problems in education, striving for professional status, certification, and licensure.

The mobility of our population will probably add to the emphasis being placed on the hospital as a community health center; and provisions in the new law for outpatient and clinic diagnostic services may further increase this emphasis. Our present supply of health manpower will be used to its limits, and any shortages in such manpower may encourage greater numbers of people to turn to hospital emergency rooms and outpatient departments for immediate, neeessary care. Physicians can respond to increased demands only to the limits of their human capacity. This fact alone may accelerate the movement into group praetice by larger numbers of practitioners.

The hospital setting presents an area for some interesting speculation. Obviously, health facility planning must either develop real teeth, real community support, and real coordination, or bow to government control.

Hospital accreditation has been a voluntary effort. *Now,* the meaning of accreditation is assuming a somewhat different significanee. The hospital medical staff must now show increasing proof that through its cooperative effort, it can and will assume responsibilities for education, quality control and, to a degree, evaluation of "physician obsolescence."

The physician must accept the evaluation of his colleagues, and unless his performanee meets their combined standards, his privileges of practicing in the institution may be lost. It's possible, therefore, to view the hospital medical staff as becoming the *de facto* surveillance group of the community for physicians in hospitals, and the county medical soeiety becoming the equivalent for physicians providing outpatient care.

### HEALTH INSURANCE

All of these factors will have an impact on the costs of medical care and the way physicians are paid for their serviees . . . an impact with many good features, many bad, but definitely an impact of magnitude.

The most obvious implication is the elimination from the voluntary insurance market of about ten per cent of the population unless voluntary

health insurance fills the gaps quickly. Future voluntary insurance programs are already being integrated with Medicare, as pension plans have been with Social Security benefits.

Also, it is only natural to expect labor and other employee groups to demand at least the same scope and type of benefits for the below-65 group as is now available to the retired. This factor alone will increase the pressures from the insurance industry to cast aside caution and to rely on the standards being established by government in lieu of previous experience and underwriting principles.

A test of some traditional concepts regarding co-insurance and deductibles is in the offing; the insurance industry will, in my opinion, be compelled to follow the experience of P.L. 89-97. Voluntary prepaid medical care insurance must change from its primary emphasis on in-hospital coverage and join the movement toward coverage for total care of the patient; it must also—in the main—follow the concepts of customary, reasonable, and prevailing fees for physicians.

Employers and the insurance industry certainly must be looking at the cost control devices demanded by government in P.L. 89-97, and it seems reasonable to expect that industry will rely increasingly on services made available by the medical profession in identifying excessive hospital and nursing home utilization, unusual fees, unusual patterns of outpatient care, and fraud. Industry will also gain from the new emphasis by hospitals on standardized cost accounting.

It is interesting to speculate on the possible acceptance, at least in part, of the Australian system of making insurance available to all, or encouraging its acquisition, by combining the elements of partial payment by the patient and fee-for-service for the physician, with the entire system being underwritten, in part, by a tax-supported subsidy.

All that I have mentioned thus far focuses on the topic given to me for today. It is now obvious that—

(1) A universal, single mode of communication, adapted to the electronic age and the needs of computers, is necessary.
(2) Due to an accelerated social revolution, ever diligent, continuing efforts are necessary to codify in precise terms the various things a physician does or can do.
(3) The government has honored, at least temporarily, the claim of the medical profession that it is truly a profession, capable of self-determination and self-discipline.
(4) The government has broken away from the static fee-schedule concept and has acknowledged the system of free enterprise, supply-and-demand, marketplace method of establishing physicians' fees on the basis of the customary, reasonable, and prevailing charges.
(5) The fee-for-service concept is also to be given a fair trial—in full public view. The basis for this comparison is built into P.L. 89-97, with special provision made for payment to closed panel group practice plans on a reasonable cost basis.

## RELATIVE VALUE STUDIES

The RVS is, in my opinion, one of the major tools available to the profession in meeting many of these challenges. There is not available, at this time, any other device which meets the communication needs of common coding and terminology of medical procedures; nor is there any better tool, readily available to physicians and administrators, which provides guidelines for determining the approximate or appropriate relationships between services performed by physicians.

The problem is to keep the document current, to redefine terms, to correct or to clarify definitions of medical procedures as these change. Let me cite one or two examples where change may already be indicated: The RVS Surgical Section has many unit values based on the global fee concept. With the expanding development of progressive levels of care, such as Hospital, Extended Care Facility, and Home Care; with dietitians, physical therapists, and visiting nurses requesting instructions, clearances, and directions; and with periodic recertification of need, the physician's sphere of responsibility is increased, his time more divided between facilities and personnel without any recognized need for concurrent change in payment.

The use of the RVS by some carriers and county society review committees, in the evaluation of customary and reasonable fees, may raise the issue of dual schedules or differential fees for various specialties. The RVS does not acknowledge the age-old argument about dual fee schedules. The theory embodied in the RVS is that equality is an inherent element in the assignment of unit values, since specialists determine unit values for procedures which *only* they can perform, while other units reflect the concept of equal payment for equal service regardless of specialty. This concept certainly seems sound to me, especially where peer judgments control the extent of a physician's professional freedom within the hospital setting. If these factors are found to have a serious effect upon the RVS, it will, of course, have to respond to new demands of medical practice.

After nearly 13 years of effort, the CMA has not produced a *perfect* document, nor does it ever expect to be able to do so. How can an RVS be flawless, in view of changes in medicine which are so complex that even general predictions are

impossible? But is there any better tool available at this point in time?

Currently, 24 state medical societies and six national specialty organizations, whose members constitute more than half of all physicians in private practice, have adopted an RVS. The AMA is now working on a national listing of coding of procedures, using its booklet, "Current Procedural Terminology," as a basis. It is being designed for use by physicians, insurance carriers, and government. This new approach, too, has its shortcomings, because any document which is national in scope will lag more in reflecting change than a state-based counterpart.

### THE INTERMEDIARY

P.L. 89-97 provides the profession with an opportunity to retain a system of payment which physicians believe in, accented by the stated desire of the U.S. Senate Finance Committee that the government *not deal directly* with physicians—but through intermediaries. That system embodies payment based on fee-for-service and interpreted on the basis of customary, reasonable, and prevailing charges, with geography, specialty, and unusual problems all taken into consideration.

An additional factor is the acknowledgement by the Federal Government and Congress that a physician's customary charge is not necessarily a static amount; that he may alter his charges at will, provided he does so for all of his patients; and that in cases commanding a higher than usual fee, that the circumstances be reviewed and recommendations made by his peers.

I have mentioned the government's recognition of the practice of medicine as a profession. Just what is a profession? Licensure by a public body is, of course, an accepted standard, but there are other standards, too.

A profession is a group of learned people who adopt higher than normal standards of behavior and accept the responsibility of self-discipline. It also is a group willing and able to exercise reasonable judgments and self-restraint, to be dedicated to a cause, and to accept public responsibility for its activities.

In the implementation of P.L. 89-97, the medical profession is being asked to assume the authority which is necessary to meet its responsibilities.

In granting the profession most of its time-honored principal elements considered necessary for the provision of high quality care, acceptance is now a public matter of

1. Free choice of physician,
2. Fee-for-service reimbursement,
3. Customary and reasonable fees,
4. Preservation of the dignity of the patient, and
5. Freedom from interference by government in the delivery of care.

These are all factors repeatedly stated to be necessary for a free profession to progress and to provide a continuous high level of care.

### TERMINOLOGY

Yet only a few days ago, a physician said to me, "You know, I'd rather be paid on a schedule based on the 1964 RVS with a $6.00 factor than on the usual and customary basis!"

After I'd recovered sufficiently, I asked the obvious "Why?"

His answer was even more surprising. "Because," he said, "I will have no responsibilities under a schedule." During the same day, another physician told me that he would rather be paid on the basis of usual and customary charges than on a fee schedule based on the 1964 RVS with a *$10.00* unit conversion factor. In response to my question, "Why?", he answered "It's the principle involved." Two different approaches, with a real potential for conflict within the profession!

Join me while I examine, in part, factors included in both statements:

Let's start with the key portions of the fee definitions used in P.L. 89-97:

*Customary* —"the customary charge for similar services generally made by the physician."

*Prevailing* —"the prevailing charges in the locality for similar services."

*Reasonable*—"in determining the reasonable charge for a physician's services, there shall be taken into consideration the customary charge for similar services generally made by the physician as well as the prevailing charges in the locality for similar services."

The term "prevailing" has other legal definitions as well. This one resulted from a court decision in Baltimore: "The word prevailing is properly construed as meaning prevalent, most general, common, predominant as current, and not as meaning *either* an average or a median."

Obviously, there are several important words in these definitions that to me can never be related to any fixed fee schedule, no matter what the value of the conversion factor. To be specific: The definitions relate to each individual physician, not all physicians, *in toto*. This means that there can be recognition for training, years of experience, time spent with a patient or difficult case, variations in overhead and variations between people. The definitions indicate that there is a range of fees which is related to the norms of a community. Certainly, the "professor type" care is not usual within a community—nor is bar-

gain-basement-type care. Fees and patterns of care should be compared, viewed or evaluated on the basis of *local customs* within a geographic locality. There is within each community, a range where fees are reasonable; there is also a level at which a fee is unreasonable. Lastly, no physician is bound by the units in the RVS, since they represent averages or norms and are recognized as guides or as a means of communication only.

There are, however, some problem areas in the usual and customary fee approach. For instance:

(1) The community range of reasonable charges may become narrow, with the elimination of highs and lows, and tend to become a spongy type of self-imposed fee schedule. True, *except* that government, in P.L. 89-97, has stated that the physician's fee is recognized to be *not* static, hence the reasonable range is moving, dynamic and flexible, not fixed.

(2) Physicians must accept great and grave responsibilities to assure the success of this approach and to meet adequately the public trust now placed in their hands.

(3) No matter what the situation, there must always be both fiscal controls and fiscal standards established and maintained by someone. This fee approach requires that physicians do this by sitting in judgment of their peers and by exercising reasonable restraint.

(4) The usual-and-customary-fee approach embodies ethics, law, and professional responsibility.

(5) The usual-and-customary approach can be very difficult for a carrier or fiscal agent to administer.

But, are these hurdles too much to expect a profession to overcome?

## FEE SCHEDULES

Let's take a look at fee schedules. One good feature which I recognize is that a schedule will help in estimating and controlling total costs. This is of real value when the profession, by mutual agreement, seeks ways to make care available to families of low income. The Blue Shield concept is based on this approach, as are many of the Foundation programs. This feature has demonstrated its value as one method of making medical insurance meaningful for millions of people.

Self-administered health and welfare plans also need some assurances of cost controls. In the absence of wide experience with usual and customary fees, the financial soundness of these types of arrangements needs to be protected.

But what are some of the bad features?

(1) A schedule pays all physicians equally without regard to the true value of their services in the open competitive market place or without regard to the quality of care provided. There is no supply and demand relationship to determine the marketable sales price of a commodity.

(2) A fixed schedule is not resilient and is slow to respond to changes in local economic conditions.

(3) A schedule tends not to recognize any variation between location of practice such as urban, rural, downtown vs. main street, or community patterns, type or scope of services demanded or needed by the patient.

(4) The fee level of a schedule is based on the economic situation of a particular employer or segment of the population—mostly a by-product of labor-management negotiations for employee fringe benefits.

(5) A schedule can be unreasonable—either high or low—and can cause either an inflation of costs to others or poor, bargain basement care for bargain basement fees, even though this latter is recognized as unsound and against medical policy.

(6) A schedule does not permit a physician to determine what he considers to be a fair profit.

(7) A schedule may hinder the scope of care a physician may render a particular patient without financial subsidy or possible loss to the physician.

In California, we have been fortunate in getting the same fee language used in P.L. 89-97 put into our state law implementing Title XIX, which became effective on March 1. It calls for customary, reasonable, and prevailing fees. At the outset of the program, it was necessary for the state designated administrative agency, our Blue Shield Plan, to set up some claims review mechanisms, so that claims falling into approximately the top third of a community range would be subject to an administrative and professional review.

CMA asked that CPS use, *as the beginning point for this review,* a countywide coefficient on the 1964 RVS for each county within the state. These figures were derived from a 1963 statewide survey of fees and adjusted for cost of living increases through 1965. After nearly four months of experience with the customary-and-prevailing-fee application, the results, in my opinion, prove that this concept is workable and sound, provided that members of the medical profession, acting through county medical society professional review committees, shoulder their responsibilities faithfully and face up to problems squarely.

To emphasize this point, since March 1, CPS has paid a total of 323,951 claims from physicians. Of that number, approximately two thirds fell within the countywide guidelines and have been paid without the necessity of special review. Of the other third, it has been estimated that less than five per cent were referred to county society review committees for study and recommendation on the reasonableness of the fees or on patterns of care.

To me, the real major difference between a schedule and the usual-customary approach is the question of standards. Who establishes them? Who enforces them and who is responsible for their modification?

## PROFESSIONAL OBLIGATION

Now that P.L. 89-97 has suddenly thrust on the profession this new responsibility and authority—which it pleaded for—what will happen if the profession fails to meet its professional obligations? Surely, a loss of prestige and a loss of

public trust and confidence. The profession of medicine stands to lose its effective voice and, in the public eye, forever relinquish its rights to a second chance or to valid consideration.

If, on the other hand, the public trust is upheld, it is reasonable to expect that the concept of usual and customary fees will become an accepted fact of life for most medical care programs.

The Foundations for Medical Care have, I believe, an exceptional opportunity to assert their leadership. More than ever before, claims review, outpatient utilization review, and cost and quality controls depend on effective interpretation of local customs and patterns. Here is your opportunity to prove that the know-how gained from other programs has qualified you to lead by example and to teach or help others who may weaken and fall by the wayside.

In Eric Fromm's book, "Escape from Freedom," he analyzes man's desire for freedom, and his flight, when it is once achieved, from its responsibilities. In discussing the problem of freedom, in its two-fold meaning, Doctor Fromm stated that freedom *from* the traditional bonds of medieval society, though giving the individual a new feeling of independence, at the same time made him feel alone and isolated, filled him with doubt and anxiety, and drove him into new submission and into a compulsive and irrational activity.

Doctor Fromm asks in his book, "can freedom become a burden, too heavy for man to bear, something he tries to escape from? Why then is it that freedom is to many a cherished goal and for others a threat?"

The medical profession must not seek to escape from its new found freedom, even though its burdens are great and its responsibilities tremendous; neither must this freedom be abused.

I firmly believe that if the profession does not fulfill the public trust and confidence as exemplified in P.L. 89-97, it will enter a new and long period of submission.

Responsibility always carries with it difficulties, yet determination and purpose can usually prevail.

An appropriate conclusion should be to quote, in Hawaiian, some great pearl of wisdom. Unfortunately, I neither speak the native tongue nor do I have a pearl. I can, however, say that I welcome this opportunity to contribute to the *customary* confusion, *prevailing* turmoil, and *reasonable* ferment. ■

Associate Director
California Medical Association
693 Sutter Street
San Francisco, Calif. 94102

*Another blank seems to have been drawn in the effort to correlate blood groups, serum types, and levels of immunoglobulin and isoagglutinins in victims of Downs disease.*

# Immunogenetic Studies on Mongolism

MITSUO YOKOYAMA, M.D.,* *Honolulu*

• *A high incidence of Fy (a+) and i positive and a lower incidence of Jk (a+) were noticed in the investigation of the blood groups, serum types, immunoglobulin levels and isoagglutinin titers of 28 mongoloid sera. No genetic correlation between these blood group factors and trisomy was defined, due to the failure to conduct a family study. Elevation of the immunoglobulin levels of mongoloids (particularly γG and γA) was found but did not show correlation with the isoagglutinin titer.*

THE TERM "21-trisomy" is used to deseribe mongolism when this abnormality is produeed by the presenee of the chromosome 21 in triplieate. In the hematologieal study of mongolism, a deerease of nuelear segmentation of polymorphonuclear leukocytes is revealed. The high ineidence of aeute leukemia among 21-trisomie ehildren implies a relationship between the two diseases. Also, the frequeney of eongenital leukemia is extraordinarily high among 21-trisomies. This assoeiation between the 21-trisomy syndrome, the leukemie proeess, and the abnormal segmentation of the polymorphonuelear leukoeytes suggests a relationship stemming from an underlying genetic cause of this disease.

Various investigators[1-4] have demonstrated a signifieant elevation of the gamma globulin level and a decrease in albumin eoneentration in the sera of mongoloid children. Nelson[4] reported an elevation also of the β-lipoprotein. Skanse and Laurell,[5] utilizing immunoelectrophoretie analysis with rabbit antiserum to speeifie immunoglobulins, found that 14 of 25 mongoloid sera showed an inerease in gamma globulin, with levels as high as 2.43 g/100 ml. Results were ealeulated aeeording to relative intensities of preeipitin lines of normal serum globulins. Nelson and Stroup[6] and Nelson[7], using immunodiffusion titration on a eellulose-acetate medium and immunoeleetrophoretie analysis, reported the γG and γA fraetions of mongoloid sera to be elevated over the eontrols, without increase in the γM fraetion.

The present authors investigated blood samples of 28 mongoloids† for their blood groups, isoagglutinin aetivity, haptoglobin and gamma globulin types, and quantitative immunoglobulin levels. The results indieate a genetie relationship betweeu various phenotypie eharaeteristies and 21-trisomy.

## MATERIALS AND METHODS

Blood samples were obtained from 28 mongoloid patients of both sexes, ranging from ages five to forty-eight. The raeial extraetion distribution of the eighteen males and ten females was twelve Japanese, seven Chinese, five Caueasian, two Filipino, and two Hawaiian. The donors were patients at the Waimano Training Sehool and Hospital, Health Department of the Hawaii State Government, Pearl City, Hawaii. The patients were healthy, with no apparent disease at the time of blood eolleetion. Two to three ml of blood were eolleeted from each donor by venous puneture and the sera were separated by eentrifugation.

The red blood eells obtained from the elotted blood were suspended in saline and washed three times. A two per eent cell suspension was prepared and added to an equal volume of antiserum in testing for the presenee of antigens of the ABO, MNSs, CDEcfV in the Rh system, $Lu^a$, $Jk^1$, K, Js, $Fy^a$, $Di^a$, and I-i systems.

The sera were inaetivated at 56°C. for 30 minutes and dilutions were made in saline for anti-A

* Kuakini Research Foundation, 347 No. Kuakini, Honolulu.
Received for publication May 3, 1966.

† Most of the patients were cytologically examined for trisomy of chromosome 21 by D. Arakaki (Chromosomal analysis of normal and mongoloid individuals of various ethnic groups in Hawaii. Genetics, 47: 939 [Aug.] 1962).

TABLE 1.—*Biographical data and blood group studies*

| SAMPLE NO. | SEX | AGE | RACE | ABO | MNSs | Rh-Hr | K | Js | $Lu^a$ | $Fy^a$ | $Jk^a$ | $Di^a$ | I | i |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | F | 5 | Chinese | O | MMss | $R_1R_1f$—V— | 0 | 0 | 0 | + | 0 | 0 | + | + |
| 2 | M | 11 | Japanese | B | MMSs | $R_1R_1f$—V— | 0 | 0 | 0 | + | 0 | 0 | + | 0 |
| 3 | M | 10 | Chinese | B | MMss | $R_1R_2f$—V— | 0 | 0 | 0 | + | + | + | + | + |
| 4 | M | 12 | Japanese | O | MNss | $R_1R_2f$—V— | 0 | 0 | 0 | + | 0 | 0 | + | 0 |
| 5 | M | 42 | Chinese | O | NNss | $R_1R_2f$—V— | 0 | 0 | 0 | 0 | 0 | 0 | + | 0 |
| 6 | M | 8 | Caucasian | B | MNss | $R_1R_2f$—V— | 0 | 0 | 0 | + | 0 | 0 | + | + |
| 7 | M | 12 | Chinese | $A_1$ | MNss | $R_1R_2f$—V— | 0 | 0 | 0 | + | 0 | 0 | + | + |
| 8 | M | 5 | Japanese | O | MNss | $R_1R_2f$—V— | 0 | 0 | 0 | + | 0 | 0 | + | + |
| 9 | M | 13 | Japanese | B | MMss | $R_1R_1f$—V— | 0 | 0 | 0 | + | 0 | 0 | + | + |
| 10 | M | 8 | Japanese | $A_1B$ | MNss | $R_1R_2f$—V— | 0 | 0 | 0 | + | 0 | 0 | + | 0 |
| 11 | F | 8 | Japanese | B | NNss | $R_1R_1f$—V— | 0 | 0 | 0 | + | 0 | 0 | + | + |
| 12 | M | 10 | Caucasian | $A_1$ | NNss | $R_1R_1f$—V— | 0 | 0 | 0 | + | 0 | 0 | + | + |
| 13 | M | 8 | Japanese | $A_1$ | MMSS | $R_1R_2f$—V— | 0 | 0 | 0 | + | 0 | + | + | + |
| 14 | M | 6 | Caucasian | O | MNSs | $R_1R_1f$—V— | 0 | 0 | 0 | + | 0 | 0 | + | + |
| 15 | M | 11 | Chinese | O | NNss | $R_1R_2f$—V— | 0 | 0 | 0 | + | + | 0 | + | 0 |
| 16 | M | 9 | Caucasian | O | MMss | $R_1R_1f$—V— | + | 0 | 0 | + | + | 0 | + | + |
| 17 | M | 13 | Filipino | B | MNSs | $R_1R_2f$—V— | 0 | 0 | 0 | + | 0 | 0 | + | 0 |
| 18 | M | 23 | Hawaiian | $A_2$ | NNss | $R_2rf$+V— | 0 | 0 | 0 | + | 0 | 0 | + | 0 |
| 19 | M | 21 | Chinese | O | MMSS | $R_1R_2f$—V— | 0 | 0 | 0 | + | 0 | 0 | + | + |
| 20 | M | 21 | Caucasian | B | MMss | $R_1R_2f$—V— | 0 | 0 | 0 | + | 0 | 0 | + | 0 |
| 21 | F | 48 | Japanese | $A_2$ | MNss | $R_1R_2f$—V— | 0 | 0 | 0 | + | 0 | 0 | + | 0 |
| 22 | F | 31 | Japanese | O | MMss | $R_1R_1f$—V— | 0 | 0 | 0 | + | 0 | 0 | + | 0 |
| 23 | F | 21 | Japanese | $A_1$ | MNss | $R_2rf$+V— | 0 | 0 | 0 | + | 0 | 0 | + | 0 |
| 24 | F | 45 | Chinese | O | NNss | $R_1R_2f$—V— | 0 | 0 | 0 | + | 0 | 0 | + | 0 |
| 25 | F | 37 | Filipino | $A_1$ | MMss | $R_2rf$+V— | 0 | 0 | 0 | + | 0 | 0 | + | 0 |
| 26 | F | 23 | Japanese | $A_1$ | MMss | $R_1R_1f$—V— | 0 | 0 | 0 | + | 0 | 0 | + | 0 |
| 27 | F | 32 | Japanese | O | MNSS | $R_1R_2f$—V— | 0 | 0 | 0 | + | 0 | 0 | + | 0 |
| 28 | F | 26 | Hawaiian | O | MNss | $R_1R_2f$—V— | 0 | 0 | 0 | 0 | 0 | 0 | + | + |

and anti-B isoagglutinin titers. Equal volumes of serum and two per cent suspensions of group A and group B red blood cells were incubated for one hour at room temperature and centrifuged at 1,000 rpm for one minute. Reactions were read macroscopically and tubes showing negative reactions were further incubated at 37°C. for one hour, after which the indirect anti-globulin test (indirect Coombs test or ICT) was applied. Haptoglobin types were analyzed by a method of Smithies.[8]

For determination of immunoglobulin levels Immuno-Plate* immunodiffusion plates containing the specific antibodies, anti-$\gamma$G, anti-$\gamma$A, and anti-$\gamma$M were used. The wells of these immunodiffusion plates were filled, using capillary pipets, with approximately 0.01 ml of the respective serum samples. In the same manner, three wells were filled with reference sera containing known concentrations of each immunoglobulin. The plates for $\gamma$G were incubated at 37°C. for four hours and those for $\gamma$A and $\gamma$M at room temperature for 16 hours. The diameter of the antigen-antibody precipitin ring was measured with a dissecting microscope equipped with a calibrated eyepiece. The concentrations of the unknown samples were carefully calculated from the curve obtained by plotting the precipitin diameters against concentration of the reference sera on semilogarithmic graph paper.

* Supplied by the Hyland Laboratories, Los Angeles, California.

SEX, AGE, RACE

The results of the blood group studies along with sex, age, and racial distribution of the patients are shown in Table 1. The distribution in the ABO system was 12 group O, 8 group A (6 $A_1$ and 2 $A_2$), 7 group B, and 1 group $A_1B$. Other blood group systems, except $Fy^a$ and $Jk^a$, showed the expected frequencies. A higher incidence of the $Fy^a$ antigen, and a lower incidence of the $Jk^a$

TABLE 2.—*Results of serum typing, immunoglobulin level and isoagglutinin titer*

| SAMPLE NO. | Hp | Gm | | | | Inv | IMMUNOGLOBULIN LEVEL (mg %) | | | ISOAGGLUTININ TITER ANTI-A | | ANTI-B | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | a | b | c | x | a | γG | γA | γM | SALINE | ICT | SALINE | ICT |
| 1 | 2-2 | + | 0 | 0 | 0 | + | 4400 | 515 | 126 | 64 | 64 | 16 | 32 |
| 2 | 2-1 | + | + | 0 | 0 | + | 1500 | 335 | 100 | 16 | 16 | 0 | 0 |
| 3 | 2-2 | + | 0 | 0 | 0 | + | 2150 | 415 | 160 | 16 | 16 | 0 | 0 |
| 4 | 2-1 | + | + | 0 | 0 | 0 | 1750 | 59 | 113 | 32 | 32 | 256 | 256 |
| 5 | 2-1 | + | + | 0 | + | + | 1030 | 73 | 100 | 32 | 32 | 64 | 64 |
| 6 | 2-1 | + | 0 | 0 | 0 | + | 3650 | 385 | 113 | 64 | 64 | 0 | 0 |
| 7 | Hp⁰ | + | + | 0 | 0 | 0 | 3070 | 151 | 113 | 0 | 0 | 64 | 256 |
| 8 | 2-2 | + | 0 | 0 | + | 0 | 2150 | 217 | 225 | 128 | 256 | 64 | 64 |
| 9 | 2-1 | + | + | 0 | 0 | 0 | 1030 | 335 | 126 | 16 | 16 | 0 | 0 |
| 10 | 2-1 | + | 0 | 0 | 0 | + | 2240 | 360 | 126 | 0 | 0 | 0 | 0 |
| 11 | 1-1 | + | + | 0 | 0 | 0 | 3070 | 310 | 126 | 128 | 128 | 0 | 0 |
| 12 | 1-1 | + | + | 0 | 0 | 0 | 3070 | 217 | 89 | 0 | 0 | 32 | 32 |
| 13 | Hp⁰ | + | + | 0 | 0 | + | 3070 | 335 | 225 | 0 | 0 | 32 | 32 |
| 14 | 1-1 | + | + | 0 | 0 | 0 | 2240 | 360 | 80 | 16 | 16 | 32 | 32 |
| 15 | 2-2 | + | 0 | 0 | 0 | 0 | 2150 | 310 | 126 | 64 | 64 | 32 | 64 |
| 16 | 2-2 | + | + | 0 | + | 0 | 3650 | 515 | 160 | 64 | 256 | 256 | 1024 |
| 17 | 2-2 | + | 0 | 0 | 0 | + | 2150 | 445 | 180 | 32 | 32 | 0 | 0 |
| 18 | 2-2 | + | + | 0 | 0 | 0 | 5300 | 480 | 142 | 0 | 0 | 16 | 16 |
| 19 | 2-2 | + | + | 0 | 0 | 0 | 2550 | 385 | 100 | * | * | * | * |
| 20 | 2-2 | + | + | 0 | 0 | 0 | 1750 | 310 | 126 | 32 | 32 | 0 | 0 |
| 21 | 2-2 | + | 0 | 0 | + | * | 1750 | 385 | 142 | 0 | 0 | 32 | 32 |
| 22 | 2-1 | + | 0 | 0 | 0 | * | 4400 | 310 | 225 | 32 | 64 | 16 | 64 |
| 23 | 2-2 | + | 0 | 0 | 0 | * | 3650 | 290 | 180 | 0 | 0 | 32 | 32 |
| 24 | 2-1 | + | + | 0 | 0 | * | 4400 | 515 | 360 | 64 | 256 | 32 | 32 |
| 25 | 2-2 | + | + | 0 | 0 | * | 1030 | 217 | 142 | 0 | 0 | 4 | 4 |
| 26 | 2-2 | + | + | 0 | 0 | * | 2150 | 445 | 225 | 0 | 0 | 32 | 32 |
| 27 | 2-2 | + | 0 | 0 | 0 | * | 2150 | 445 | 142 | 32 | 32 | 16 | 16 |
| 28 | 1-1 | + | + | 0 | 0 | * | 3070 | 445 | 360 | 64 | 64 | 64 | 64 |

* Not tested.

antigen, were noted. One Japanese and one Chinese subject were positive. In the I-i system, the group showed a high distribution of i antigen.

Table 2 shows the results of haptoglobin and gamma globulin typing, the immunoglobulin levels and isoagglutinin titers of mongoloid sera. Haptoglobin typing revealed 14 with type 2-2, 8 with type 2-1, 4 with type 1-1, and 2 with Hp⁰ type. The Gm were distributed as follows: 15 Gm (a+b+c—x+), 9 Gm (a+b—c—x—), 2 Gm (a+b+c—x+), and 2 Gm (a+b+c—x+). No Gm (c+) factors were found in this study. Among the Inv types, 12 were Inv (a—) and 8 were Inv (a+). Eight sera were not tested for Inv.

### IMMUNOGLOBULIN LEVELS

Most of the sera showed a higher than normal level of each immunoglobulin. Immunoassay of the gamma globulin levels showed twelve cases having γG levels significantly higher than 3,000 mg/100ml and nine cases over 2,000 mg/100ml; in the γA fraction, 22 cases showed a level of more than 300 mg/100ml, three over 200 mg/100ml, and 16 cases of over 100 mg/100ml. These results indicate an increase of γG and γA fractions in many of the mongoloid sera, and in some cases a significant increase in the γM fraction. The average immunoglobulin levels of mongoloid sera were calculated to be 2,663 mg/100ml for γG, 342 mg/100ml for γA, and 158 mg/100ml for γM. The average levels in female serum were 3,007 mg/100ml for γG, 316 mg/100ml for γA, and 134 mg/100ml for γM, while the values for male serum were 2,472 mg/100ml for γG, 388 mg/100ml for γA, and 203 mg/100ml for γM. Both γA and γM globulin levels were found to be higher among the males than among females.

Thirty-six normal human sera each, of male and female, gave immunoglobulin levels ranging from 820 to 1,550 mg/100ml, with an average of 1,292 mg/100ml in the female and 1,185 mg/100ml in the male for $\gamma$G; $\gamma$A globulin levels ranged from 85 to 260 mg/100ml, with an average of 164 mg/100ml in the female and 140 mg/100ml in the male. Normal $\gamma$M concentrations averaged 98 mg/100ml in the female and 105 mg/100ml in the male, ranging from 55 to 145 mg/100ml.

Anti-A and anti-B isoagglutinin titers generally fell within a normal average range (1:16 to 1:156 for anti-A and anti-B), using saline titration and the indirect Coombs test. One serum showed a higher than normal anti-B titer, the indirect Coombs indicating the titer to be 1:1024.

## DISCUSSION

In these studies, the occurrence of mongolism did not correlate generally with sex, age, blood groups, and serum types. However, the higher frequency of the $Fy^a$ factor and a lower incidence of $Jk^a$ may indicate some genetic correlation, possibly influenced by the Asiatic background of the Hawaiian population. Chown, Lewis, and Kaita,[9] in a study of 22 families in which mongolism occurred, reported a typical inheritance in the Duffy blood factor and one anomaly in the ABO system.

## i ANTIGEN IN MONGOLOIDS

Of note was the detection of the i antigen on the red cells of nearly half of the mongoloids studied. The i antigen, maximally developed at birth, usually decreases in strength during the first year of life and disappears normally within eighteen months[10]. Associated with this decrease is a reciprocal increase of the I antigen, which is poorly developed at birth[11]. Essentially, therefore, the i antigen should be found only in those below two years of age. Giblett and Crookston[12], however, found that the red cells of patients with blood dyscrasias and neoplastic diseases were strongly agglutinated by anti-i. That approximately half of the mongoloid samples showed similar agglutination patterns may give some insight as to the disease process involved in mongolism. However, the I antigen on the red cells of the mongoloids studied showed normal reactivity against the anti-I serum, although McGinnis, Schmidt, and Carbone[13] found a decrease in the I-antigen reactivity in hematological diseases, including leukemia.

Serum types did not show any correlation with mongolism but the levels of immunoglobulins were found to be increased in most cases. An unusually high incidence of pneumonia and other respiratory infections has been noted among mongoloids. The susceptibility of the patients to infection might lead one to expect a rise in isoagglutinin titers, since many organisms contain blood-group substance. However, there did not appear to be any correlation between the high serum immunoglobulin levels and isoagglutinin titers. The elevation of immunoglobulins in mongoloids could be due to the increased instance of infection, or could be explained on the basis of increased genetic dosage, or could possibly be due to both of these factors.

The far larger percentage increases in $\gamma$G and $\gamma$A than in $\gamma$M have interesting implications. However, the elevation in $\gamma$M is probably of little significance.


## ACKNOWLEDGMENT

The author expresses his gratitude to Dr. Edward T. Chin, the Waimano Training School and Hospital, Health Department of the Hawaii State Government, Pearl City, Hawaii, for his arrangement of blood samples.

The author is also indebted to Mrs. Clair Ball, former graduate student of the Department of Genetics, University of Hawaii, for her assistance; Mr. Kingdon Lou, Immunology Research Department, Hyland Laboratories, Los Angeles, for his gammaglobulin analysis; and Dr. F. Paul Alepa, National Institution of Arthritis and Metabolic Diseases, National Institutes of Health, Bethesda, for his Gm-Inv typings.

A part of this study was supported by the Memorial Fund for Lois A. Mayers.


## REFERENCES


1. Stern, J., and Lewis, W. H. P.: Serum proteins in mongolism, J. Ment. Sci. 103: 222 (Jan.) 1957.
2. Sobel, A. E., Strazzula, M., Sherman, B. S., Elkan, B., Morgenstren, S. W., Mairus, N., and Meisler, A.: Vitamin A absorption and other blood composition studies in mongolism, Amer. J. Ment. Defic. 62: 642 (Jan.) 1958.
3. Carver, M. J., Wiltse, H., and Wittson, C. L.: Basic studies in mongolism, Dis. Nerv. Syst. 20: 162 (Apr.) 1959.
4. Nelson, T. L.: Serum protein and lipoprotein fractions in mongolism, Amer. J. Dis. Child. 102: 369 (Oct.) 1961.
5. Skanse, B., and Laurell, C.: Immune globulins in mongolism, Acta Med. Scand. 172: 63 (July) 1962.
6. Nelson, T. L., and Stroup, G.: Immunological study of gamma and beta-2 globulins in mongoloids, Abstracts of Pediatric Research, Atlantic City, New Jersey, 94 (May) 1963.
7. Nelson, T. L. Immunoglobulins—electrophoretic and immunoelectrophoretic findings in mongoloids, J. Tenn. Dept. Ment. Hyg. 9: 48 (Sept.) 1964.
8. Smithies, O.: Zone electrophoresis in starch-gels: group variations in the serum proteins of normal human adults, Biochem. J. 61: 629 (Dec.) 1955.
9. Chown, B., Lewis, M., and Kaita, H.: Atypical Duffy inheritance in three Caucasian families: a possible relationship to mongolism, Amer. J. Human Genet. 14: 301 (Sept.) 1962.
10. Marsh, W. L.: Anti-i: A cold antibody defining the Ii relationship in human red cells, Brit. J. Haemat. 7: 200 (Apr.) 1961.
11. Tippett, P., Noades, J., Sanger, R., Race, R. R., Susais, L., Holman, C. A., and Buttimer, R. J.: Further studies of the I antigen and antibody, Vox Sang. 5: 107 (Feb.) 1960.
12. Giblett, E. R., and Crookston, M. C.: Agglutinability of red cells by anti-i in patients with thalassemia major and other hematological disorders, Nature 201: 1138 (Mar.) 1964.
13. McGinnis, M. H., Schmidt, P. J., and Carbone, P. P.: Close association of I blood groups and disease, Nature 202: 606 (May) 1964.

*Leukemia in children in Hawaii follows the mainland pattern; mainly acute, mainly lymphoblastic, and mainly in boys.*

# Childhood Leukemia in Hawaii
## Experience at Kauikeolani Children's Hospital

CLAUDE D. LAURIAULT, M.D.,* and ROBERT T. S. JIM, M.D.,** *Honolulu*

• *Children's Hospital in Honolulu admitted 42 cases of leukemia from 1954 to 1964. There were 24 boys and 18 girls. Peaks of incidence occurred in the 5-7–year and the 13-15–year age groups. Incidence was much higher in 1959 and 1960, and in 1963, than in any other years. Monthly incidence showed lowest incidence in winter and highest in summer, except for a sharp drop in August. Hawaiians had five times their expected share and Caucasians less than half theirs, but the differences were not statistically significant.*

CHILDHOOD malignancies, including leukemia, are now the leading cause of death from disease in the United States between the ages of three and 14 years.[1] In Hawaii leukemia in infants and children appears to be as prevalent as in the mainland United States. In this report the past 11 years' experience with leukemia at Kauikeolani Children's Hospital in Honolulu, Hawaii, is reviewed.

### MATERIAL

There were 42 cases of leukemia admitted to the Kauikeolani Children's Hospital during the period 1954-1964 inclusively. All were acute leukemias with the predominant morphologic type being lymphoblastic, and a smaller percentage myeloblastic or monoblastic. The chart of each patient was reviewed with regard to the age, sex, monthly incidence, yearly incidence, and ethnic group.

### RESULTS

*Age:* The majority of cases of leukemia were in the three to seven-year-old age group with the peak incidence at the five to seven-year-old age group, and a smaller second peak at the thirteen to fifteen-year-old age group (Fig. 1). The lowest incidence was found in the eleven to thirteen-year-old age group.

TABLE 1. *Ethnic background of leukemia cases.*

| | CASES OF LEUKEMIA NO. | CASES OF LEUKEMIA % | RACIAL DISTRIBUTION IN HAWAII * (IN %) |
|---|---|---|---|
| JAPANESE | 15 | 36 | 32 |
| CHINESE | 5 | 12 | 6 |
| CAUCASIAN | 5 | 12 | 30 |
| FILIPINO | 5 | 12 | 11 |
| HAWAIIAN | 2 | 5 | 1 |
| SAMOAN | 1 | 2 | <1 |
| MIXED ORIGIN | 9 | 21 | 20 |

* 1960 CENSUS

*Fig. 1. Age distribution of leukemia.*

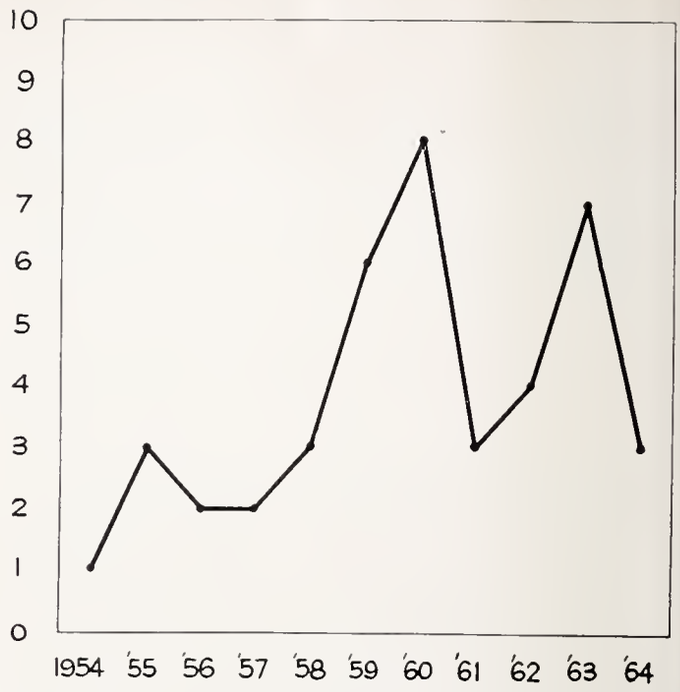



* Resident, Kauikeolani Children's Hospital.
** Associate Clinical Professor of Medicine, University of Hawaii School of Medicine.
Received for publication March 1, 1966.

*Fig. 2. Monthly incidence of leukemia.*




*Fig. 3. Yearly incidence of leukemia.*




*Sex:* Of the 42 eases of leukemia, 24 were boys and 18 were girls.

*Monthly Incidence:* The peak ineidenee for leukemia appeared to oeeur during July with a relatively lower ineidenee during the winter months and a sharp drop in incidenee in August (Fig. 2).

*Yearly Incidence:* The yearly ineidence for leukemia appears to have inereased sinee 1959, however, with decreases in ineidenee in the years 1961-1962 and 1964 (Fig. 3).

*Ethnic Group:* The raeial background for the 42 eases of leukemia is shown in Table 1. The Chinese, Hawaiian, and Samoan groups appeared to show a relatively higher ineidenee while the Caucasians appeared to show a lower ineidenee for leukemia.

## DISCUSSION

Childhood leukemia appears to be as prevalent in Hawaii as in the mainland United States. The age distribution eurve for ehildhood leukemia in this study eorresponds elosely to other published reports, with the peak age ineidenee in the three to seven-year-olds.[2, 4] In addition, a seeond smaller peak age ineidenee noted in teenagers has also been found by others.[5] The higher incidenee of male over female leukemia eases found in this study has also been seen by other investigators.[3, 4]

While the seasonal incidenee for leukemia varies among published series, the peak seasonal incidenee in this study appeared to oeeur during the month of July. The yearly incidence for leukemia in this 11-year period appeared to show an over-all upward trend; however, the deelines in ineidenee in the years 1961, 1962, and 1964 remain unexplained.

Probably none of the racial groups in Hawaii shows a greater or lesser incidenee for leukemia. The number of eases of leukemia in this study is too small to warrant eonelusions regarding racial predilection. The raeial distribution of cases of leukemia appears to be proportionate to that of the population.

## SUMMARY

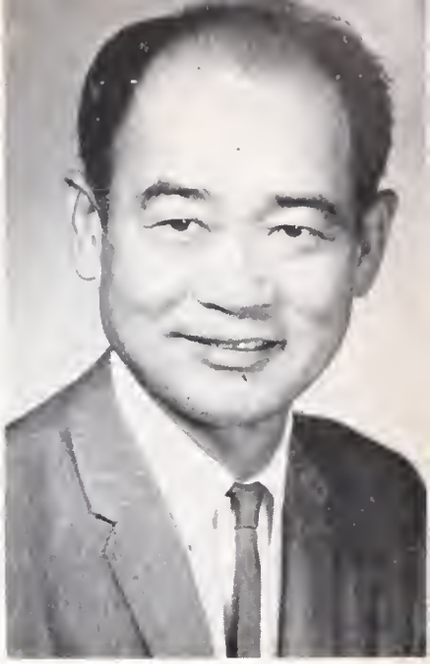
Forty-two cases of childhood leukemia oeeurring in the period 1954 to 1964 inelusively at Kauikeolani Children's Hospital were reviewed. All were acute and primarily of the lymphoblastic type, the remainder being myeloblastic or monoblastie. Males predominated over females. Analysis of the age distribution eurve revealed a peak age ineidence in the three to seven-year-old group, with a second smaller peak in the teenage group. The peak ineidenee for leukemia oecurred in the month of July. An over-all upward trend was noted over the 11-year period. The prevalenee of leukemia appeared to followed the raeial distribution in Hawaii. In general, childhood leukemia in Hawaii as experieneed at Kauikeolani Children's Hospital seems to follow the same pattern as that of the eontinental United States.

## REFERENCES

1. Arey, James B., in Nelson, W. E., Textbook of Pediatrics, 8th Ed., W. B. Saunders, Philadelphia, London, 1964, p. 1506.
2. Meighan, S. S.: Leukemia in children, JAMA 190:126 (Nov. 16) 1964.
3. Wintrobe, M. M.: Clinical Hematology. Lea & Febiger, Philadelphia, Pennsylvania, 1961, p. 906.
4. Smith, C. H.: Blood Diseases of Infancy and Childhood. C. V. Mosby Co., St. Louis, Missouri, 1960, p. 383.
5. Davies, A. M., Modan, B., Djaldetti, M., and de Vries, A.: Epidemiological observations on leukemia in Israel, Arch. Intern. Med. 108:86 (July) 1961.



# *The President's Page*



The 89th Congress has passed Medicare, with its far-reaching Title XIX programs, as well as numerous other health bills such as Heart, Cancer, & Stroke; Comprehensive Mental Retardation Centers; and Preventicare.

The new philosophical concept is that quality comprehensive medical care must be made available to everyone within certain geographic regions.

In order to carry out this concept, the medical schools will be the hubs of the regional centers. However, the medical school can no longer remain as an "Ivory Tower." In the requirements promulgated by Congress, NIH will set up the standards and dispense the necessary funds.

Research and education in themselves will not be sufficient. The medical schools must make their facilities available to everyone within their regional scope. It is also required that the Advisory Committee must be composed of not only educators, but representatives of hospitals and medical societies, and of important consumer groups from business and labor.

On the surface, this philosophical concept appears innocuous, but it is frightening how much federal, state, and local governmental agencies will be directly involved in the future practice of medicine.

The impact of this concept has not been fully realized by the medical profession. We cannot remain fragmented, as we are, and expect our voices to be heard in a meaningful way. To become effective as the dispenser of the services, which will be required of us, we must present a united front.

Theodore Tomita, M.D.

HAWAII MEDICAL JOURNAL

# Editorials

## Foundation For Medical Care

This has been the year of the first faltering steps for the Foundation in the field of actual promotion and sale of contracts by the insurance carriers.

Four insurance companies are offering Foundation coverage as this is written, with several others giving serious consideration to participation, some of them awaiting only word from their home offices. The outlook is good for a growing volume of participation.

One of the stumbling blocks to full development is the lag in physician understanding. Techniques for communicating with the doctors are being studied and much remains to be done along these lines. More than a hundred members of the Society are still not participating in the Foundation program.

Some criticism has been leveled at the plan by the physicians who say that the conversion factor is too low. It has been set at 5.00.

There is a good and substantial reason for this. The oldest prepaid plan on the islands—HMSA—has set its unit value at 4.50, and unfortunately some physicians have been accepting this as full payment. This has had a broad set of results, not the least of which has been the proposal by the Workmen's Compensation Bureau of a fee schedule built around the same factor of 4.50. Other complicating results of this involve the margin of costs to the insurance carriers. They have to be in a reasonably competitive position, and with the burden of paying a premium tax (HMSA is exempt from this) and a 10 per cent differential in the amount of claims for service, they cannot meet the price of the package set by HMSA.

The position thus established is indeed an unhappy one, but in part is the responsibility of the profession. We have permitted this to happen, and it is up to us to see if we can't work ourselves out of the morass of inequities that we have let develop. One way is to get the Foundation off the ground and into a good competitive position so that the insurance carriers can establish the Foundation concept as one that is good and desirable for the community as a whole.

Once this is accomplished, then fees can be adjusted on a realistic basis. We then will have a good, healthy accident and health insurance business in Hawaii, on a sound competitive basis. Let us pray that that day comes soon.

The Foundation has established an office in the Mabel Smyth Building. For the moment Mr. Thorson is acting as Administrator of the Foundation and Miss Lynda Nelson is the clerk processing the claims. The Review Committee has been functioning and all claims that have been filed have been paid as rapidly as possible—most of them within 24 hours.

At the present writing (October 17, 1966) there are five contracts in force, with more coming into being by the first of November. By the time this is published it is hoped that the volume will have shown a marked increase.

No landslide of contracts is to be expected. It will take time for the monopoly now existing to be broken down. The physicians can help by understanding what the Foundation is and what it can do for their patients. In the long run it will help the doctor, because from open competition in the health and accident insurance field, will come progress, and with physician guidance it can do much to alleviate the economic pressures of the costs of health care on the public (your patients).

J. J. Lowrey, M.D.
*President,* Honolulu County
Medical Society

# The Aloha United Fund: Preliminary Report

Physicians distinguished themselves—as compared to previous performances, that is—by their generosity during the official period of Honolulu's first Aloha United Fund drive. They gave almost $20,000 — nearly triple the average of the past three years, and 75 per cent more than their best year to date. The average contribution from those who gave was a little over $100—not quite the suggested "fair share," but probably very close to half of it for most donors. Since the "goal" arbitrarily set by the Fund's campaign brains was—based on past years' performances—a modest and realistic $15,000, we topped it at nearly 125 per cent. The attorneys, who have in the past run neck and neck with us, did much better; the dentists, who have usually lagged well behind us, did just as well.

What is really mysterious about our performance—and, unless some explanation can be found for it, embarrassing, as well—is the fact that only one practicing physician out of three gave *anything* to the Fund. The donations came from less than 190 doctors—about a third of those in practice.

As a result, the average donation per physician in practice was roughly $40, or $3.50 per month —not a very munificent amount to spend for helping to maintain the institutions and organizations that our own children use—the Boy Scouts, the YMCA and YWCA and YBA, the Girl Scouts—and the major health agencies. If physicians had responded as well as truck drivers and stenographers did, the medical profession's contributions would have been closer to $120,000 than $20,000.

An analysis of the pattern of giving by physicians may give us some answers to the problem. We'll let you know if it does.

# Looking For Lost IUD's

The intrauterine contraceptive devices have had and are having widespread publicity and public acceptance over recent years. This is in large part due to the overwhelming vote of confidence given to them by the medical profession. Because 10 to 20 per cent of the IUD's are expelled spontaneously, especially during the first six months after insertion, periodic pelvic examination by a physician or self-examination by the patient is necessary to insure their presence in the uterus. On rare occasions when there is doubt as to the presence of the device in the uterine cavity, x-ray examination may be required to detect a radio-opaque IUD. Because of the hazards of irradiation, however, routine x-ray examination in lieu of pelvic examination is not recommended. Then, too, as a means of deteeting any pelvic abnormalities including cancer, routine pelvic examination is sound medical practice.

# Hawaii Academy of General Practice

## The Profession and the Practice

Thirty years ago—a generation ago—the physician practiced his profession.

Today, the practicing physician not only has this to do, but he must also take the time to be an economist, a working economist.

### THE CARE OF THE PATIENT

Despite modern methods, despite instant laboratory and x-ray, despite the rapidity of action and the efficacy of the new wonder drugs, the modern physician must spend just as much time with his patient as his dad did.

Victor Heiser or Arthur Hertzler may have spent a lot of their time holding the reins loosely, as the horse and buggy plodded along. They would spend hours on one house call, taking care of one patient, while the many other sick took care of themselves, and quite capably too. The standard joke of the day was: "The doctor saved my life; he didn't come when he was called!" The implication was that the patient was saved from bloodletting and purging. However, other than showing a casual concern for remuneration unhampered by any complexity in figuring out his income tax, the horse-and-buggy doctor really could devote his full time to the care of his patients' illnesses. He could, at least, read or meditate on things medical or surgical while his transportation took care of itself.

### THE CARE OF THE PRACTICE

How different it is with some of our modern physicians!

I say some, because many of us are not in this category; the most of us, labelled "The Leaners," are wholly dependent upon the good work of "The Lifters." We want to devote our entire effort to the care of the patient. Fortunate for the patient it is, that this is so! We would ask these physicians to come out of their cloistered edifices in office and hospital in order to put their shoulders to the wheel of medical economics, but we cannot criticise them too vehemently for doing what we should all be doing—healing the sick and injured on a full-time basis.

Other modern medical men have awakened to the realization that within this last 30-year period the economics of the practice of medicine has been taken over and manipulated by nonphysicians in a manner inimical to our interests. We now have MEDICARE, the epitome of Third Party Medicine, intervening by law, and attempting to manage the sacred patient-doctor relationship. Now, finally, we physicians are slowly becoming organized, and are being indoctrinated into the economics of medicine. We are not only becoming educated in matters other than the cure of diseases, but we are learning rapidly how to call upon professionals, in the fields of law and economics, to assist us. We have smartened up!

The Lifters are doing this at considerable sacrifice. There are not more than 60 minutes in an hour; therefore, the care of the patient must necessarily be limited, when the physician has to devote time to the care of the profession. The Lifter gets no additional remuneration for this (the attempt of HEW to bribe him with pay to serve on a Utilization Committee is indeed reprehensible), which means the Leaners benefit doubly from the efforts of their "crazy" colleagues.

The recent public hearing on a proposed fee schedule for Workmen's Compensation is a case in point. The four physicians who "testified," under the guidance of the Association's able lawyers, obviously had to have done their homework in long hours of meetings and study, for the presentation on behalf of the Hawaii Medical Association to have been so well put together as to be incontrovertible. The two economists who also testified for us were invaluable in the evidence they presented.

It was truly heart-warming, and it was proof of the growing awareness of the profession to the import of all this, to note how many of our colleagues were in the audience at this hearing. Perhaps this alone is enough reward for the Lifters—to see the Leaners show interest and indicate a willingness to help "lift," too!

All of us need to understand that, in order to preserve for our profession and for our patients the highest in quality medical care, it has become necessary for some of us to be experts in the economics of medicine. Those of us who are not suited for this odious task should share the burden, in return for participating in the benefits. ■

J. I. FREDERICK REPPUN, M.D.
*Secretary*

HAWAII MEDICAL JOURNAL

# This Is What's New!

• **Bleeding** in patients with **uremia** is predominantly an abnormality of **platelet function.** Uremic patients with abnormal bleeding invariably had prolonged IV bleeding time and impaired platelet aggregation and clot retraction. The commonly used screening tests for bleeding disorders, namely **capillary fragility** bleeding time, and total platelet count, were rarely abnormal. The qualitative platelet abnormality is improved by **dialysis.** (*Lancet* [July 9] 1966.)

• **Hypertension** in slightly over 200 patients studied in Tennessee was associated with significant **renal artery stenosis in 21 per cent** of the patients studied. The family history of hypertension was as common in patients without renovascular hypertension as in those with renovascular hypertension. The highest percentage was found in the first two decades. A mid or upper **abdominal bruit** was the only finding in history or physical examination which correlated significantly with the renal artery stenosis. The rapid-sequence excretory urogram was more valuable as a screening test than the renogram. Split renal function study was recommended after arteriography if a lesion was detected. (*Surgery* [July] 1966.)

• Of the eleven hundred cases of **Guillain Barré syndrome** studied in San Francisco, **one-third had no demonstrable cause.** The remaining two-thirds were associated with many different conditions, mainly various types of **infections,** although allergies, endocrine disturbance, neoplasms, and toxins also were found. Regardless of the cause or presumptive cause of the **Guillain Barré** syndrome, **demyelinization** was the common denominator. (*Arch. Int. Med.* [August] 1966.)

• The material known as the **rheumatoid factor,** which is responsible for the positive Waaler Rose sheep cell agglutination reaction in patients with rheumatoid disease, is a macroglobulin. The small fraction of this macroglobulin necessary to provide the typical hemagglutination reaction has a **sedimentation constant of 6S.** (*Läkartidningen,* Stockholm [June 15] 1966.)

• Studies carried out in the California State Mental Hospital indicate that **early discharge from a mental hospital** is more dependent on the **optimism of the therapist** than any other single factor. Mental hospital discharge records over the last 100 years indicate that the patients hospitalized between 1852 and 1870 had an excellent chance of early hospital discharge. The era prior to the turn of the century was marked by therapeutic optimism in contrast to the therapeutic pessimism in the early 1900's. (*Arch. Gen. Psychiat.* [Nov.] 1966.)

• The increasing incidence of **chloasma** found in Australia has been attributed to increased use of **oral contraceptives** there. The chloasma is attributed to stimulation by sunlight of melanocytes synthetized or primed by the hormones. (*Med. J. Australia* [July] 1966.)

• A **reticulum cell sarcoma** of the hamster has been **transmitted to another hamster** by the **mosquito** Aedes aegypti. The tumor cells of the hamster's sarcoma remained viable for 8 hours after ingestion by the mosquito. The transmission rate was 5 to 10 per cent. (*Cancer* [Oct.] 1966.)

• In a retrospective study of patients with viral hepatitis carried out in Germany, **no cases of cirrhosis** were found which could be **ascribed exclusively** to the earlier episode of **hepatitis.** Patients with clinical or laboratory evidence of chronic liver disease invariably had such associated diseases as alcoholism, diabetes, et cetera. The three patients with frank cirrhosis were all severe alcoholics. (*Deutsch. Med. Wcschr.* [Oct. 7] 1966.)

• **Plasma renin,** like many other biochemicals, has a diurnal pattern. The highest values of plasma renin are obtained between 2:00 A.M. and 8:00 A.M. and the lowest values between noon and 6:00 P.M. This **decrease in plasma renin in the afternoon** needs to be taken into consideration if diagnostic tests, particularly those in regard to hypertension, are to be interpreted with precision. (*J. Clin. Invest.* [Oct.] 1966.)

• **Carcinoma of the lung** may result in the liberation of **antidiuretic hormone,** with low serum sodium and various neurological manifestations. The differential diagnosis includes cerebral metastases from the carcinoma, cerebral degeneration associated with the carcinoma, cerebrovascular disease, et cetera. Fluid restriction is the only means of controlling symptoms. (*J. Thoracic and Cardiovasc. Surg.* [Sept.] 1966.) ▪

FRED I. GILBERT, JR., M.D.

# In Memoriam - Doctors of Hawaii

This is the sixty-fourth installment of In Memoriam—Doctors of Hawaii.

## Charles Barton

Charles Barton was born on June 10, 1881, in Toledo, Ohio, the son of Robert William and Laura (Coates) Barton.


DR. BARTON

Educated in Toledo grammar and high schools, he also attended Culver Military Academy. He then attended the University of Michigan until 1908. His M.D. was granted by Detroit Medical College (Detroit Homeopathic College) in 1909. Dr. Barton interned at Grace Hospital in Detroit, 1908-1909, and at Flower Hospital in New York from 1909 to 1910.

For several months in 1910 the doctor served as surgeon to an exploration party of the Madeira-Mamoré Railroad Company in the upper Amazon valley. Between 1910 and 1911 he served as medical officer on the Hamburg-American Steamship Line. The remainder of 1911 and 1912 was spent on the staff of the Metropolitan Hospital in New York, and the following year he was appointed to the staff of the New York Ophthalmic College and Hospital in the same city. During 1913-1914 Dr. Barton served as first assistant to Dr. Royal S. Copeland, prominent ophthalmologist of New York. He was also able to attend various American and European eye and ear clinics.

Dr. Barton began his military service in 1913 by enlisting in the New York National Guard. In 1916 he saw service on the Mexican border with the 31st Michigan Infantry, and in the following year the doctor organized and commanded the American Red Cross Ambulance Company No. 8 in Detroit. From 1917 to 1919 he served as Chief of Ophthalmology at the Base Hospital at Camp Zachary Taylor in Kentucky.

While he was stationed at Camp Taylor, the doctor married Henrietta Martha Kiesow on October 21, 1917.

Dr. Barton entered private practice in Detroit in 1914 where he was visiting ophthalmologist at Grace Hospital from 1914 to 1915 and oculist with the Detroit Board of Health the following year. In 1919 Dr. Barton came to Honolulu and served as oculist with the Hawaii Board of Health examining the eyes of school children throughout the Territory, a position he held until 1921. He was also engaged in private practice in Honolulu, specializing in diseases of the eye, ear, nose, and throat.

In 1924 Dr. Barton got into difficulties over promoting an eye remedy called "Sparkles," and was suspended for unethical conduct by the Medical Society of Hawaii. Dr. Barton left the Territory in February of that year.

The doctor subsequently made his home in Los Angeles and served for a time as assistant city health officer.

Dr. Barton died December 30, 1944, in Los Angeles at the age of 63.

He was a member of the Medical Society of Hawaii, the American Medical Association, Honolulu Ad Club, American Legion, B.P.O.E., and the Beta Phi and Alpha Sigma fraternities.

## Frederick Emerson Allen

Frederick Emerson Allen was born at Worcester, Massachusetts, on January 20, 1868, the son of Benjamin Thayer and Elizabeth Usher (Emerson) Allen. His first forefather in America was John Alden. On his mother's side, he was a descendant of Ralph Waldo Emerson.


DR. ALLEN

He received his early education in the schools of Massachusetts and at Effingham Academy, New Hampshire. Later he studied at night schools and entered the College of Physicians and Surgeons, which granted him his medical degree in 1901. This was followed later by postgraduate work and observation studies at Johns Hopkins and the Boston Psychopathic Hospital.

Dr. Allen entered professional practice in San

*continued page 148*

HAWAII MEDICAL JOURNAL

# Book Reviews

## ★The Burn Wound

*By Captain Stanley E. Order, M.D., and Colonel John A. Moncrief, M.D., 72 pp., $7.75, Charles C. Thomas, 1965.*

FROM THEIR VAST burn experience at the Brooke Army Medical Center, the authors approach the problem of handling burns from the standpoint of site of the initial injury, the burn wound. From animal experimentation as well as human clinical findings, they discuss in detail the microscopic findings of the second and third degree burn wounds. Interesting pictures of arteriograms as well as microscopic findings are well presented. The authors discuss burn wound sepsis with special reference to Pseudomonas aeruginosa. A method of reducing this sepsis with the consequent lowering of mortality is also presented. The newer technique of using homografts and autografts, and even heterografts, is also discussed.

All in all, I would recommend this book highly.

LEABERT R. FERNANDEZ, M.D.

## ★Radiologic Diagnosis in Infants and Children

*By Armand E. Brodeur, M.D., M.Rd., F.A.C.R., 503 pp., $26.50, The C. V. Mosby Company, 1965.*

THIS VOLUME will be welcomed by those interested in pediatric radiology. It is well organized and well indexed. The numerous radiographs used throughout are generally of excellent quality. Certain reproductions in which details might be obscure are accompanied by helpful line drawings.

The emphasis throughout is on practical problems apt to be encountered in the diagnosis of infants and children. Unusual and less common conditions are given little emphasis. The terminal section of each chapter, called "Pitfalls in Diagnosis," points out common errors. This will be of help in avoiding mistakes of judgment and evaluation.

This book should prove to be a valuable addition on the reference shelf, next to Caffey's monumental *Pediatric X-ray Diagnosis,* of radiologists, pediatricians, and other physicians interested in the diagnosis of disease in infants and children.

RICHARD D. MOORE, M.D.

## ★Respiratory Care

*By R. H. Bendixen, L. D. Egbert, J. Hedley-Whyte, M. B. Laver, and H. Pontoppidan, from the Respiratory Unit and the Anesthesia Laboratory of the Harvard Medical School at the Massachusetts General Hospital, Boston, Massachusetts, 252 pp., $15.00, The C. V. Mosby Company, 1965.*

THIS CLEAR, succinct, compact text on basic pulmonary physiology as applied to clinical medicine covers the evaluation and management of the more common respiratory problems. The material is easily assimilated because it is readable and practical. The book abounds with graphs, diagrams, and tables.

It is highly recommended to all clinicians as an invaluable guide in handling the perplexities of respiratory care.

HENRY H. C. FONG, M.D.

★ means highly recommended.

## The Heart and Circulation: Community Services and Education, Vol. II

*Second National Conference on Cardiovascular Diseases, Edited by E. Cowles Andrus, Associate editor Cyrus H. Maxwell, 282 pp., U.S. Government Printing Office, Washington, D.C., 1964.*

VOLUME II is a smaller issue summarizing community services and education. This covers many of the administrative and operational aspects of these programs.

RICHARD T. MAMIYA, M.D.

## Parkinson's Disease: Trends in Research and Treatment (A Symposium)

*Edited by André Barbeau, M.D., F.R.C.P. (C), Lewis J. Doshay, M.D., Ph.D., and Ernest A. Spiegel, M.D., 171 pp., $7.75, Grune & Stratton, 1965.*

THIS LITTLE 171-page book contains the 24 papers presented at a symposium on Parkinson's disease at Miami Beach in 1964, sponsored by the National Parkinson Foundation. It is an excellent résumé of the latest in Parkinson's disease.

Perhaps the most exciting new idea in Parkinson research is that advanced by Dr. André Barbeau and his group at the University of Montreal—that it may be due to a metabolic defect in the metabolism of dopamine or related chemicals. There has been some attempt to treat Parkinsonian symptoms with L-Dopa and there has been some improvement in the akathesia but the rigidity and tremor have usually persisted.

The last section of this symposium has been limited to the neurosurgical and physiological aspects of Parkinson's disease and some interesting comments on campotomy (destruction of Forel's field) are presented. Apparently, there are some distinct advantages of campotomy as compared to the usual thalamotomy.

MICHAEL M. OKIHIRO, M.D.

## ★★Endocrine System and Selected Metabolic Diseases, Vol. 4

*By Frank H. Netter, M.D., The Ciba Collection of Medical Illustrations. 287 pp., $22.00, published by Ciba, 1965.*

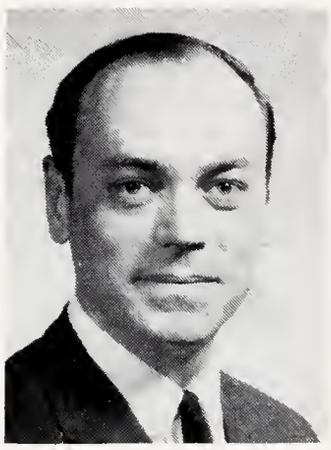
BOOK REVIEWS can never do justice to Frank Netter's works; they have to be seen and read to be fully appreciated, but then whose haven't? Granted, his illustrated volumes will require text revision as our knowledge advances; nevertheless they will continue to be used by generations to come, for Frank Netter combines the rare genius of a great artist with a medical researcher's curiosity, attitude, and knowledge. He makes the dry anatomical descriptions and metabolic schemes of our lecture rooms come alive. The medical student and the practicing physician alike, after reviewing the living diagrams and illustrations, can make a coherent whole of the fragmentary information he gathers through reading and lectures.

Anyone even remotely connected with the medical profession should be familiar with the Netter volumes on the nervous, reproductive, and digestive systems. With

*continued page 158*

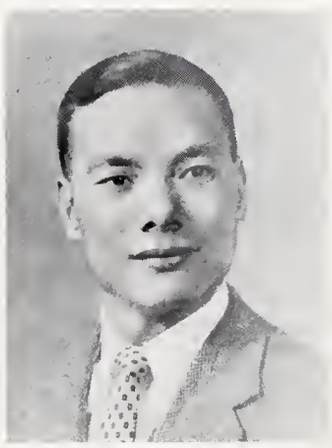
HAWAII MEDICAL JOURNAL

# New Members



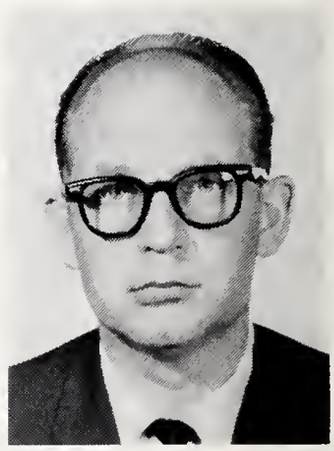
**Juris Bergmanis, M.D.**
1133 Punchbowl Street
Honolulu, Hawaii 96813

NEUROSURGERY
University of North Carolina, 1956
Internship—NC Memorial Hospital, Chapel Hill, N. C., 1956-57
Residency—NC Memorial Hospital, Chapel Hill, N. C., 1957-59 and 1962-63



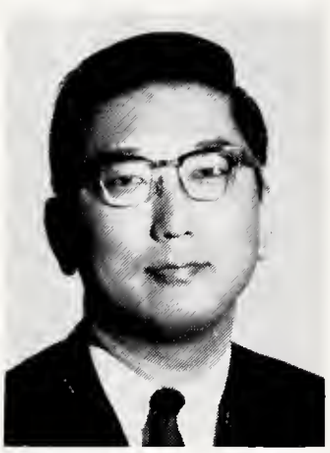
**S. Thomas Lee, M.D.**
1697 Ala Moana Blvd.
Honolulu, Hawaii 96815

ANESTHESIOLOGY
Taiwan University—1953
Internship—Taiwan University Hospital—1952-1953
Holyoke Hospital—1957-1958
Residency—Surgery—Taiwan University Hospital—1953-1955
Thoracic Surgery—Univ. Clinic Dusseldorf—1955-1957
Anesthesia—Duke University Hospital—1958-1960



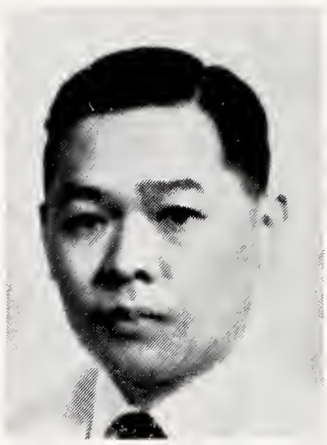
**James Hall Stewart, M.D.**
1133 Punchbowl Street
Honolulu, Hawaii 96813

UROLOGY
New York Medical College, 1960
Internship—The Queen's Hospital, 1960-61
Residency—The Queen's Hospital, 1961-62
New York Medical College, 1962-65
The Queen's Hospital, 1965-66



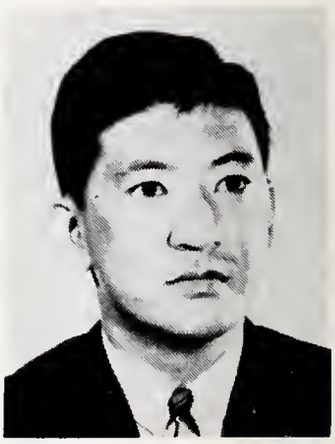
**Arthur T. Osako, M.D.**
1481 South King Street, Suite 223
Honolulu, Hawaii 96814

PEDIATRICS
Universtiy of Rochester, 1959
Internship—Denver General Hospital, 1959-60
Residency—University of Washington, 1963-65



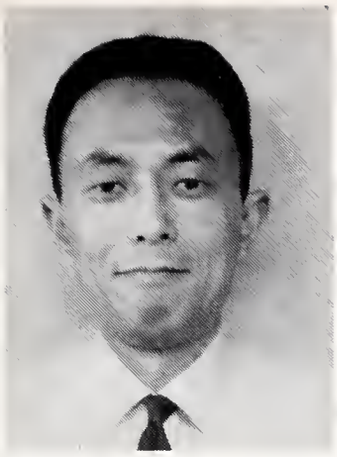
**Walter H. K. Watt, M.D.**
1415 Kalakaua Avenue, Suite 210
Honolulu, Hawaii 96814

INTERNAL MEDICINE
The Creighton University, 1957
Internship—The Queen's Hospital, 1957-58
Residency—VAH, Martinez, Calif., 1964-66
VAH, San Francisco, Calif., 1963-64
Highland-Alameda County Hospital, Oakland, Calif., 1962-63



**Herbert S. Uemura, M.D.**
Kauikeolani Children's Hospital
P. O. Box 3799
Honolulu, Hawaii 96812

PATHOLOGY
University of Nebraska College of Medicine, 1960
Internship—Madigan General Hospital, Tacoma, 1960-61
Residency—Bishop Clarkson Memorial Hospital, 1961-65



**Takakazu Fukumura, M.D.**
2525 Coyne Street
Honolulu, Hawaii 96814

GENERAL PRACTICE
Keio University School of Medicine, Tokyo, Japan, 1953
Internship—6407th USAF Hospital, 1953-54
Kuakini Hospital, 1965-66
Residency—Mallory Institute of Pathology, Boston City Hospital, Boston, Mass., 1954-1955
General Surgery, Bradford Hospital, Pa., 1955-56
General Surgery, Hazleton State General Hospital, Hazleton, Pa., 1956-57
Pulmonary Diseases, Philadelphia General Hospital, 1957-59
General Surgery, Keio University Hospital, 1959-65

# *County Society News*

## Hawaii

One guest, Dr. Henri P. Minette, attended the August 18 meeting. The business portion included a discussion on the status of HMSA negotiations and the complaints of patients relative to late checks. It was announced that Dr. Hudson, AMA President, would be in Hilo September 15 and Dr. M. J. Friedenberg, radiologist, September 28. It was voted to donate $200 to the Health Facilities Planning Council. Questions were developed relative to Medicare Part B billing problems and Utilization Committee activities. Dr. Eklund advised that he would resign as government physician. The guest speaker, Dr. Minette, spoke on "Zoonoses."

Dr. Marvin J. Friedenberg was a guest at the September 28 meeting. Dr. Matayoshi was appointed chairman of the Health Fair Committee and Dr. Loo of the Diabetes Committee. Committee reports were received from Dr. Mitchel, on Utilization Committee, and Dr. Miyamoto, on Medicare. It was voted to contribute $200 to the Health Facilities Planning Council. A donation of $1,500 was voted to the Scholarship Fund. There is approximately $20,000 in the Scholarship Fund and at the present time four individuals are receiving loans.

## Honolulu

New members Ellis F. Devereux, Gurcharn Koch-Brar, Raymond Chock, and Jordan Popper were introduced to the approximately 165 members present at the June 7 meeting. The featured speaker for the evening was Bob Krauss who talked on "Vietnam As I Saw It." The balance of the program was devoted to a presentation on the current status of the Medical Plaza.

Approximately 170 members were present at the September 6 meeting. New members Edwin Gramlich, James Johnston, Roy Kuboyama, S. Thomas Lee, Raymond Wong, Mitsuo Yokoyama, and Henry Watanabe were introduced. A tribute was paid to the late Dr. Frank H. Hatlelid. Reports were made on the United Fund Drive, the Postgraduate program featuring Dr. Lillehei, the Diabetes Drive, the Nominating Committee, HMSA, the Foundation for Medical Care, and the Medical Plaza. Awards were made to the three winning medical assistants.

## Kauai

Guests at the July 5 meeting included Dr. Luke, who spoke on cardiopulmonary resuscitation, and members of the Kauai Nurses Association. Following the movie and demonstration of resuscitation techniques, Dr. Kim advised that additional funds were available for continued cytology screening. Also that measles and trivalent polio vaccines were available from the Department of Health without cost.

Dr. Miyashiro reported on requests for KCMS members on HMA committees. Drs. Goodhue and Warner were appointed to establish a Health Fair Committee on Kauai. It was voted to invite Dr. Hudson to Kauai. It was also voted to advise the orthopedic surgeon inquiring as to practice possibilities on Kauai that at the present time there would not be a need for such a physician; currently Kauai is adequately covered by the consultants from Honolulu.

The role of the Home Health Advisory Committee was reviewed with special attention to the areas of medical supervision by the attending physicians, reordering of narcotics, and emergency anaphylactic reaction. Dr. Wallis reported that Dr. Joan Takeuchi, anesthetist at Wilcox who also does general practice, would be on maternity leave and there was urgent need for a physician to replace her. It was voted that there was a need for another temporarily licensed physician.

## Maui

At the April 26 meeting President Haling presented the Society's Utilization Plan and the amended proposal was accepted by a vote of 16 to one. The application of Dr. Dorothy Antonia Wood was unanimously accepted. The President was instructed to establish a three-member committee to look into the possibility of the Grievance Committee's serving as the County Claims Review Committee. The Hawaii RVS was accepted with a conversion factor of five to become effective May 1. The meeting concluded with a discussion of the lack of communication with the HMA.

The report of the Committee on Medical Ethics was presented by Dr. Iaconetti at the May 26 meeting. He was appointed to serve in an advisory capacity in future potentially questionable action relating to medical ethics. Members of the Society and news media were urged to confer with him if such occasions arise. Dr. Haling advised that a number of members had not included the HAMPAC contribution with their annual dues. Dr. Moran gave a report on the highlights of the HMA's House of Delegates.

A dinner meeting was held at the Wailuku Hotel on September 1. Dr. Lawrence Allred was accepted into membership by transfer from San Joaquin County Medical Society. Dr. Iaconetti presented a report on the recent HMA Council meeting. It was voted to obtain insurance protection for liability and slander actions against officers and committee members. The program concluded with a talk by Dr. Scott Brainard on the "Implantation of Cardiac Pacemakers." ■

HAWAII MEDICAL JOURNAL

# Notes and News

## Professional Moves

We apologize for our tardiness in reporting some of the migrations of Homo Sapiens Medicus, local variety. On the Windward side, Surgeon **Kazushi Tanaka** moved to the Kaneohe Medical Bldg. while Internist **Winfred Chang**, Pediatrician **Jim Mertz**, Obstetrician **Hamilton Winston**, the husband-wife team of **Anna Maria** and **Roger Brault**, and **Mor J. McCarthy** moved into the new Kailua Professional Center. Also on the Windward side, Kaiser's new $1 million Kaneohe Clinic was dedicated recently.

On the Leeward side, **Daniel Semenoff** joined the Kaiser Maili Clinic and Pediatrician **Edward Kagihara** associated with **Joe Nishimoto** at the Pearl City Medical Bldg.

We congratulate the rest of those brave and hardy souls who located in town. They are Pediatrician **Arthur Osako**, who joined the Central Medical Clinic; Orthopod **Don Maruyama** and Internists **Keiichi Goshi** and **Francis Ikezaki**, who moved into the Medical Arts Bldg.; Psychiatrist **Theodore Chun** and Plastic Surgeon **Victor Hay-Roe**, who located at 1441 Kapiolani Blvd.; and Internist **Walter Watt**, who opened at the King Kalakaua Bldg. We also welcome the new brood at the Kaiser Hospital at Ala Moana, *viz.*, Surgeon **Paul Matsumoto**, Obstetrician **Gordon Ontai**, and Anesthesiologist **S. Thomas Lee**, plus **Janis S. L. Lee**, and **Martin Redlich.**

On Maui, the Maui Medical Group added a new member, **Lawrence Allred**, and opened a new clinic recently in Lahaina. **M. L. Hanlon, W. E. Iaconetti, J. F. Morris, Seiya Ohata, W. B. Patterson, L. S. Rockett, M. Tofukuji**, and **B. A. Weeks** were on hand for the opening ceremonies.

An item of interest is the report from the Health Department that the most recent roster of licensed physicians in Hawaii shows 1,235 names, but that only 845 are in Hawaii. The remaining 390 practice elsewhere, and this includes good ole **Charley Judd** in Samoa. Deputy Director **Walt Quisenberry** reports that it is common practice for physicians licensed here to hold onto their licenses because many hope to return.

## Visiting Physicians

We were blessed by a continuous flow of medical educators filtering through; each leaving his indelible impression on our medical community. In August, sunburned, athletic **Robert E. Cooke**, from Johns Hopkins, was the Visiting Professor at Children's Hospital and at the local tennis courts. Gangling **Jan Waldenström** from the University of Lund, Sweden, was Visiting Professor of Medicine at The Queen's Hospital from August 11 through 17, where he lectured on his favorite subjects, Waldenström macroglobulinemia, and other related diseases. **Ralph A. Deterling, Jr.**, from Tufts University

### FRANK HALL HATLELID
### 1908-1966

Frank Hall Hatlelid was born July 2, 1908, in Grafton, North Dakota. His goal of achieving a higher education in the fields of medicine was engendered by his father, who was a pharmacist in Grafton, and his mother, who was a school teacher. His undergraduate work was completed at the University of North Dakota, where he was on the football team, rifle team and golf team. He received a B.A. degree in 1930 and his B.S. degree in 1932, concomitantly receiving a commission as Second Lieutenant in the U. S. Army through his ROTC training while at college.

He attended Rush Medical College, Chicago, and received his M.D. degree in 1935, subsequently interning at St. Luke's Hospital, San Francisco. In 1936, he was assistant resident physician at St. Luke's, and, in 1937, became chief resident.

Dr. Hatlelid developed a perennial interest in the sea from the date when he served as ship's surgeon for the liner "Mariposa" in 1938. In later years, he was active in the Waialua Boat Club and skippered his own small boat in Hawaiian waters.

His continuing interest in the military was maintained through active participation in the National Guard before World War II, including competition in regional pistol and rifle matches. During World War II he became an Army surgeon with the 40th Division, seeing duty in the South Pacific theater. He was discharged from the Army in 1946 with the rank of Lt. Colonel.

Dr. Hatlelid came to Waialua Agricultural Company as a plantation physician in January of 1946. He was subsequently appointed Medical Director of that sugar company in 1952 and held this position until his death. As such, he was active particularly in the Association of Plantation Physicians and Industrial Medical Association, having served as regional counselor at one time. Also, he was a member of the American Medical Association, the Hawaii Medical Association, Association for Military Surgeons, and the Phi Delta Theta Fraternity. He also took an active part in community groups, working with the American Legion; he was a member of the Waialua Lions Club; and he participated in various community projects.

A conscientious physician, Dr. Hatlelid was instrumental in improving the medical services rendered in the rural community of Waialua. Dr. Hatlelid died at the Waialua Hospital on August 15, 1966, of carcinoma of the pancreas. He is survived by his wife, the former Mary Tree Watson, of Stillwater, Oklahoma; a daughter, Mrs. Kevin Morris, of New York City; and a son, Douglas, of Hollywood, California.

RODMAN B. MILLER, M.D.

Medical School, was Visiting Professor of Surgery from August 1 to 25. He covered organ transplants, cardiac surgery, and the tumoricidal effects of laser beams. Also in August, **Philip Levine**, renowned leader in immunohematology and Director of Research for the Ortho Research Foundation, held discussions with the Kuakini Research Foundation and Kuakini Hospital staff while en route to the International Congress of Hematology in Sydney, Australia.

We were amused by Prof **Takio Shimamoto**, Director of the Cardiovascular Disease Institute at Tokyo Medical University, who pointed out that the average heart attack patient in Japan is five years older than his American counterpart and stressed the role of bradykinin in arteriosclerosis. He felt that henpecked American males are more prone to heart attacks than their Japanese counterparts because Japan is still a man's world. He pointed out that whereas the American husband returns home tired after a day's work and is obliged to help his wife with housework, and unable to relax from the stress of daily life, the Japanese husband returns home and has nothing to do except to eat and relax.

During September and October, **Harry C. Shirkey**, Professor of Pharmacology at Samford University and Director of the Pharmacology Division of the Pediatrics Department at University of Alabama Medical College, delighted us with his witticisms as Visiting Professor at Children's Hospital.

**Leion Schiff**, Professor of Medicine from the University of Cincinnati College of Medicine, gave a week's lecture series at Queen's in early September covering the differential diagnosis of jaundice and treatment of liver diseases.

**Charles L. Hudson**, President of the AMA, was here for the 10th biennial meeting of the Pan Pacific Surgical Congress in September. Regarding Medicare, he commented wisely, "We recognize this is the law and will try to do all we can to make it work."

## Conference Humor

We felt smug that our gout indicated higher intelligence when it was reported that full professors had higher uric acid levels than assistant profs and that college kids had higher levels than noncollege kids, but **Bob Cooke**, visiting pediatric professor, squelched our little egos by pointing out that mongoloids (or Down's syndrome to the knowledgeable) also had high uric acid levels.

In discussing the role of mercury in acrodynia, Visiting Professor **Harry Shirkey** quoted the oft heard saying, "One moment with Venus and a lifetime with Mercury" . . . Of course the present twist is 2 million units of penicillin, but that doesn't lead to any interesting quotes.

The difficulty of sex determination in some pseudohermaphrodites was emphasized by humorist **Harry Shirkey** who defined a girl as "looking like a girl, acting like a girl, and having an extra X chromosome."

Bespectacled, mop headed, serious **Jan Waldenström** in his quaint Swedish accent, discussed the genetic aspects of porphyria and revealed the hazards of genetic investigation with the following story: It seems that an investigator was making a genetic study of a young man with six fingers and six toes. The young man categorically denied that his condition was inherited and convinced the investigator that his mother had been frightened by a neighbor with six fingers and six toes when she was pregnant.

Sober, effective lecturer **Jan Waldenström** described the thirst mechanism as being in the hypothalamus. He commented, "Some people, like myself, will not touch a glass of water unless something is in it." This brings us to speculate that perhaps we have something wrong with our hypothalami.

While discussing the pros and cons of steroid therapy in hepatitis, grey-haired, soft-spoken **Leion Schiff** with his newly acquired tan, put on a slide showing the SASH phenomenon. Someone had nerve enough to admit his own ignorance and ask what this phenomenon was. Leion smiled like a cat which had just swallowed a canary and replied almost casually, "SASH stands for Steroids Almost Started Here."

On yet another day, while discussing the causes of haemobilia, Leion related how he had been trapped into a wrong diagnosis in a clinical-pathological conference. "They say the only way you catch a turtle is when it sticks its neck out. . . . Well, I stuck my neck out and got caught."

Our apologies to Dr. Stein. . . . A 13-year-old Oriental female with RLQ pain, hirsutism, masculinization, and amenorrhea, with elevated androsterone and androstenedione levels and normal plasma cortisol was described at a Kuakini surgical conference by an enthusiastic intern as having a "sustained" Leventhal syndrome.

*Picturesque Speech:* Surgeon **Bob Oishi**, discussing the relative merits of the conventional versus modified radical neck, described the latter as somewhat akin to a "berry picking exercise" (i.e., picking out the lymph nodes only). Pathologist **Frank Fukunaga**, describing a slide of papillary cystadenoma, pointed to an area heavily populated with cancer cells and in characteristic concise language said, "Here, we see a more 'juicy' area."

## Community Notes

**Mario Bautista** and **Henry Manayan** are directors of a Forty-Up Club composed of elders from the local Filipino community who are over forty and active in community affairs.

**Windsor C. Cutting** of the Medical School accepted a $25,000 check from Eli Lilly & Co., an unrestricted gift to further the teaching research programs of the new U.H. School of Medicine.

**Stanley Kobashigawa** was carnival co-chairman for a two-day carnival bazaar at the Pearl City Hongwanji Mission, designed to raise funds for a building program commemorating the Mission's 60th anniversary.

At Lt. Governor Andrew Ing's testimonial dinner, **Duke Choy** presented the Lt. Governor with a new set of golf clubs and appropriately commented, "Golf is a game played over 19 holes and the 19th hole is fraught with danger." To counter this danger, he presented Mrs. Ing with a baseball bat.

**Alton Ochsner** was in town to address the annual meeting of the Oahu Unit of the American Cancer Society at the Hilton Hawaiian Village and preached his familiar gospel of smoking hazards. "A smoker's chance of dying from lung cancer is 1,000 per cent greater than a nonsmoker. He has a 510 per cent greater chance of dying from bronchitis or emphysema and a 540 per cent greater chance of dying from peptic ulcer." He described cigarette smoking as a form of suicide and added, "It is as lethal as putting a bullet in your head." At the same meeting, **Robert Rigler** was installed as president and other newly elected physician board members included **Henry Manayan, Randal Nishijima, L. Q. Pang, Calvin Sia,** and **W. H. Wilkinson. George Mills** installed the newly elected officers.

Busy **John Devereux** is kept even busier politicking for his wife, Representative Dorothy Devereux, who is running from the 15th District. Between delivering babies at night, seeing patients during the day, he posts campaign posters, stuffs envelopes, drives campaign workers, and checks news releases.

**Dick Ando,** Chairman of the State Board of Education, in a nonpolitical talk at the Honpa Hongwanji Mission School PTA stated that how well a child does in school is determined largely by his preschool training from his parents and the affection he gets.

## Hors De Combat

We saw the following item: Eli Lilly's 1964 report to stockholders states, "The average physician in the U.S. works 60 to 70 hours a week, sees 20 to 30 patients a

*continued page 148*

HAWAII MEDICAL JOURNAL

Hawaii Medical Association

## MINUTES OF THE COUNCIL MEETING

**August 31, 1966, at 6:30 p.m.**
**Oahu Country Club**

### PRESENT

Theodore T. Tomita, presiding; Drs. Batten, Chinn, Fong, Iaconetti (for Dr. Andrews), Ivy, Miyamoto, Miyashiro (for Dr. Wallis), Pinkerton, Richardson, and Sloan, plus Drs. Bronder, Helms, Kuhlman, Lowrey, Miller, Moore, and Willett, and Messrs. John Staggs, (Director, Medicare Division of Aetna, Mr. V. Thomas Rice (HMA Legal Counsel), and Mr. H. Tom Thorson (Ex. Secretary, Honolulu County Medical Society).

### MINUTES

The minutes of the March 24, 1966, meeting were approved as printed in the JOURNAL.

### COMMUNICATIONS REQUIRING ACTION

***Pharmacy Committee:*** A request from the Pharmacy Committee was received. The committee wants to recommend to the AMA's Council on Drugs that prescriptions for drugs instruct the pharmacist to "Label As Such" rather than "Take As Directed" and where the instructions are involved say "use as per written on instructions." The purpose of the recommendation is to have the label state name of drug and show exact dosage directions.

**ACTION:**

**It was voted to approve the Pharmacy Committee's request.**

***Hawaii Visitors Bureau:*** The HVB is soliciting funds for their educational campaign and would like to use the HMA offices to help spread the word in the following three ways: (1) A mailing to HMA members of a new brochure being prepared; (2) A showing at one of the meetings of their new 28-minute slide presentation on the visitor industry; and (3) An endorsement by the HMA Council to the membership urging their support of the campaign either accompanying the mailing of the brochure of appearing in the HMA publication.

**ACTION:**

**It was voted to accept the first request of the HVB regarding a mailing to HMA members of a new brochure they are preparing.**

**It was voted to commend the HVB on its work in promoting tourism in Hawaii, and to inform them that it is the policy of the Hawaii Medical Association to contribute through the individual members.**

### REPORT OF THE SECRETARY

The Secretary's three recommendations were discussed and acted upon as follows:

**ACTION:**

**It was voted to approve the first two recommendations of the Secretary as circulated; i.e. membership census and referral to the Bylaws Committee of problems involved in membership reporting.**

**It was voted to have the HMA liability policy endorsed to include protection against slander and libel to give protection to members of the committees acting in an official capacity, and to write the four county societies to caution them of the inherent dangers of not carrying liability insurance.**

### REPORT OF THE TREASURER

The Treasurer's Report was noted and discussed, and a few technical changes made which are as follows: (1) Under "Budget for 1966-67" the last sentence should read: "This adjusted budget figure for income over expenses is $1,337.50, but there will be further adjustments after the auditors arrive. (2) Under "Travel Allowances" the third sentence should read "I feel the Council should permit members to travel by first class, I feel that the doctors traveling on Association business should be fully reimbursed for their expenses, i.e., for first-class tickets and up to $50.00 a day for actual expenses incurred. The fifth sentence was deleted. The sixth sentence should start with the word "Doctors" rather than "They."

**ACTION:**

**It was voted to approve the Treasurer's report as corrected, and to approve the Treasurer's recommendations as circulated; i.e., (1) that Mr. Lytle be reimbursed for attending the PR meeting in Chicago, (2) that Mr. Ajifu's monthly fee be increased to $150.00, (3) that the physicians traveling for the Association be fully reimbursed for their expenses in first-class plane fare and up to $50.00 a day—to be paid upon receipt of detailed expense vouchers.**

### NEW BUSINESS

***Implementation of Title XIX:*** Dr. Tomita gave background information on the status of and negotiations with the Department of Social Services relevant to government physicians.

***Negotiating Committee of the AMA:*** The Negotiation Committee is asking support from the Council for their negotiations with DSS for a conversion factor of 5.0 across the board based on the Hawaii Relative Value Study with a subsidy of 20 per cent in surgery and anesthesiology and 30 per cent in medicine to apply for a six-month period, ending June 30, 1967.

**ACTION:**

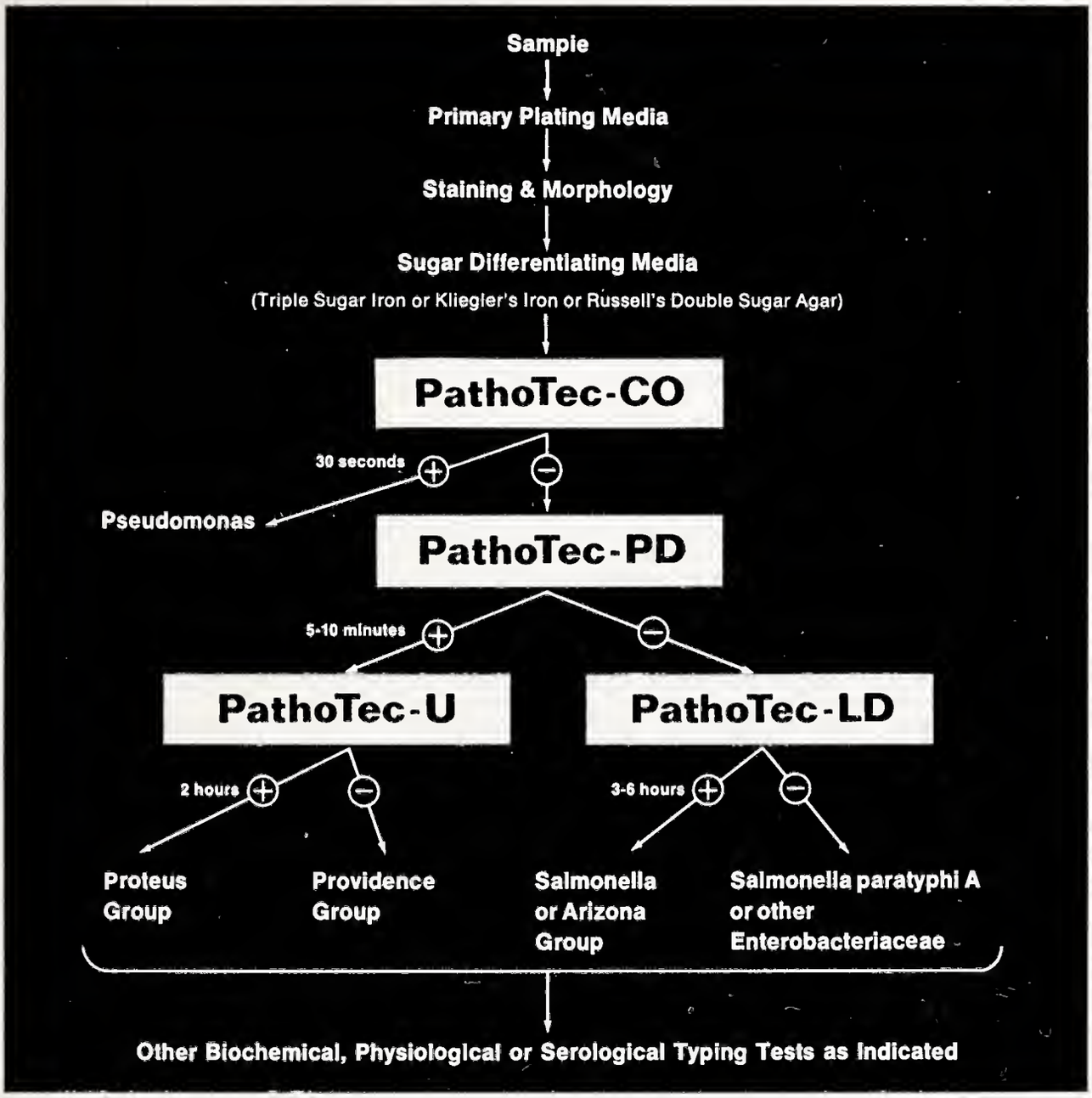
**It was voted that the Council go on record favoring the Negotiations Committee's approach in this matter.**

***Hospital Outpatient Departments:*** There was considerable discussion about hospitals instructing all DSS clients covered by Medicare to go to their private physicians. It was noted that one hospital does not do this. This problem was discussed by the Hospital Committee. It was also noted that the House of Delegates passed a resolution re Hospital Practice of Medicine and that this resolution was sent to all hospital administrators and chairmen of the board.

**ACTION:**

**It was voted that the Council reaffirm the resolutions re Hospital Practice of Medicine and Free Choice of Physician and send notice of**

*continued page 154*




## An aid in rapid identification of certain gram-negative bacteria

The diagram shows how PathoTec™ can simplify the testing for four enzyme reactions frequently used in diagnostic microbiology. These tests would require 24 hours to 3 days by conventional methods. Now they can be performed within 30 seconds to 6 hours!

PathoTec test papers are coated with premeasured, standardized reagents, including a substrate and a color indicator system. They eliminate special preparation of reagents or media required to perform these tests by conventional methods. Always ready for use; indefinitely stable when stored in refrigerator and protected from light.

**PathoTec-CO** [cytochrome oxidase] • **PathoTec-PD** [phenylalanine deaminase]
**PathoTec-U** [urease] • **PathoTec-LD** [lysine decarboxylase]

GENERAL DIAGNOSTICS Division Warner-Chilcott Laboratories, Morris Plains, N.J.

# HAWAII TECHNOLOGISTS' BULLETIN

*Official Publication of the Hawaii Society of Medical Technologists*

*Editor:* LOUISE WULFF, MT(ASCP), University of Hawaii

## *A Med Tech in Asia*

I recently returned to Hawaii to take up residence again after four and a half years of living and working in Asia. The three areas in which I worked were Afghanistan and Malaysia, where I served with Medico, and Nepal, where I spent the past year with the Thomas A. Dooley Foundation.

I wish I had a technical paper to present. I'm afraid about the only set of statistics I can pull out of my head just now is that from my observations about 80 per cent of the population of Asia has intestinal parasites, and if you narrow the age range to Asians 12 and younger, then the percentage jumps to about 95 per cent. (The other 5 per cent no doubt are infested too, but you have to make some allowance for lab error.) For the above reasons I loved doing stools for "O & P."

Seriously, though I am rather ashamed of not having done a little research on the side, it certainly wasn't from lack of things to investigate. Although I suppose the majority of patients seen in the hospitals and clinics to which I was assigned suffered from exactly the same ailments that would hospitalize a North American, there was still a good measure of what we might call the exotic. There was malaria, of course, sometimes asymptomatic but occasionally invading the brain or causing severe hemolytic anemia. At least two patients were brought to the Lipis District Hospital in hemolytic crisis due to Leptospira. Filariasis is commonplace in Nepal, although in some areas where infection was placed at 10 per cent, no evidence of elephantiasis was discovered. Then there are the dysenteries, amebic and bacillary, common in both Afghanistan and Malaysia.

I should note here that in both Afghanistan and Malaysia I was working in hospitals. In Nepal the majority of my time was spent working with a National Health Survey where whole populations of selected areas, healthy as well as sick, were studied. For a period of five months I did run chemistries and serologies for one of the Kathmandu hospitals, but I worked in a lab converted from the kitchen of one of the Foundation houses. Specimens were brought to me from the hospital and I never learned the diagnosis of any of these cases.

So I am more aware of prevailing illnesses in Afghanistan and Malaysia than in Nepal. All three countries still have cholera outbreaks to contend with, though rarely in Afghanistan. In Afghanistan I saw smallpox for the first time. We had three cases in the hospital during a mild outbreak. Smallpox is defeated in Malaysia, uncommon in Afghanistan, and even in Nepal, where people still die or are disfigured by it, it is on the decline. Vaccination is available free to all in the cities and health teams are now beginning to cover the rural areas. But some areas in Nepal are often a five- or six-day walk from the nearest air strip.

To continue with some more conditions which were encountered which might be of interest: gonorrheal ophthalmia of the newborn; Hansen's disease (quite common in Malaysia); also in Malaysia, Mycobacterium ulcerans, which destroys the skin and underlying tissues. M. tuberculosis is common in all three countries, and in Afghanistan very frequently invaded all organs. I was able to culture it from one spinal fluid. S. typhosa and other Salmonella were cultured regularly in Afghanistan and Malaysia. In Afghanistan we saw several deaths due to typhoid, usually from intestinal perforation and peritonitis. Sometimes the patient would not enter the hospital until all other hope of recovery was abandoned. But many times the patient lived in a remote area and was unable to get medical attention in time.

I could continue the list but this will give an idea of what came in besides gallbladder disease, heart failure, and women having babies. I am very grateful to all the Medico and Dooley doctors for their willingness to discuss the cases; answer questions; and permit me, when I had time, to follow along on rounds and to call my attention to anything they thought might be of interest to me. I'm sorry I wasn't able to answer more of their questions. I would strongly advise anyone going overseas, and particularly anyone going to an isolated area, to take along lots of good reference books. It's pretty hard when you don't have a pathologist to turn to and the nearest help may be far away. In Malaysia the excellent Institute of Medical Research was only 120 miles distant but in Nepal our parasitology consultant was Marguerite Beatty of Kaneohe, thousands of miles and two or three weeks removed. So you wind up being the only authority (to use the term loosely) in the vicinity and the doctor wants you to "just take a look at the bone marrow and tell me what you think" or "just look at the sputum and see if you think there are malignant cells."

I would like to give a brief picture of the three areas with regard to type of work the lab did and some idea of the facilities for training technicians. Afghanistan was my first, and still favorite, post.

Medico worked in an 80- to 90-bed general hospital in Kabul. We were given a fairly free hand by the Ministry of Health to teach, improve, and reorganize. I was blessed with an extremely cooperative counterpart. He is a man older than I, one who still kept his wife veiled and might understandably be reluctant to have a woman step in and take over. He was eager to learn new tests and highly appreciative of all our beautiful new equipment (which took six months to arrive). We had at one time or another in the lab, a second technician, a lab assistant, a messenger (an old man who wore a khaki overcoat summer and winter and never went anywhere without his old chest x-rays), a cleanup boy who doubled as tea brewer, and two students. The students were both young men, perhaps 20 or 21, who had had a secondary education and two years of theoretical lab training at the Central Public Health Laboratory in Kabul.

The lab, which is the country's only technician training center, is under the direction of a very capable man with graduate degrees from Cambridge, but he was hampered by lack of equipment, supplies, and qualified personnel. I was very pleased when he suggested that I take two of the students for their practical training. The boys managed to forget everything they learned during theory and most of what they must have learned in secondary school in the half-block walk from the Public Health Lab to Avicena Hospital. Total amnesia for everything from blood cell counts to long division! But they shaped up quite well, all things considered.

I really loved that lab and everyone in it. When Medico arrived the lab equipment consisted of a monocular scope, a two-place hand centrifuge which devoured glass, a nonbright-line hemocytometer with a broken cover glass, and one RBC, one or two WBC, and two Sahli pipettes, most with broken tips. There was a bottle of Benedict's, one of acetic acid, a tea pot, and not much else. So my first few weeks were spent placing orders and designing lab furniture. When I left Kabul we had a fairly smooth running outfit doing about what a small United States hospital lab would do. There was plenty of room for improvement, but I left satisfied.

In Malaysia, Medico had a different function. Again we were placed in a general hospital, this time in a small town in the center of the Malay peninsula. Our role was to supplement the local staff rather than to teach or renovate. Of course, Malaysia is hardly an underdeveloped area, and has had its own health system for some time, which has proved quite satisfactory. My Malaysian counterpart was a Chinese man who took his training at the Institute of Medical Research. Except for bacteriology he was able to handle almost anything. Besides the two of us, we had a lab assistant who washed glassware and dip-sticked urines, and this was the lab staff for a 180-bed hospital with a daily out patient Clinic of 150 to 200 persons. We worked a six-day week and alternated weeks on night call.

In Nepal the lab work was not particularly interesting. Most of my time was spent looking for malarial parasites. This can be exciting in areas where the Eradication Teams (USAID supported) have not yet reached. But it was deadly dull in places where they had sprayed for four consecutive years. A second technologist ran PCV's, STS's, and typhoid and typhus agglutinations. Yet from a nonwork viewpoint it was a most interesting assignment.

Among other things I learned: to put up and take down tents, light kerosene lanterns, live out of a duffel bag, load helicopters, unload oxcarts, ride an elephant, and work, eat, read, and even bathe, with a constant audience of fascinated Nepalis. In one camp during the two days of helicopter shuttling of people and equipment to the next survey site, enterprising business men set up food stalls on our camp grounds to accommodate the hundreds who walked miles to watch this spectacle.

The biggest cross I had to bear work-wise in Afghanistan and Malaysia was the blood bank. Oh, you Honolulu techs who need only pick up the telephone and order two B's and one A and one platelet-rich this and that, as if you were ordering one quart skim and two whole from the milkman! And even you in the blood bank with your row on row of files of people who actually want to give blood! It was not the crossmatching; it was getting something to crossmatch. In Malaysia I had the unique experience of jumping up from the donor cot and running in to the lab to do the crossmatch. But in Lipis we did have a list of regular donors. In fact they were so regular you would run through the list and everyone would have been tapped the month before. In Kabul we had no regular donors. The patient might have ten relatives accompanying him to the hospital but try to get them to donate! Of course many of them eventually did or we could not have carried on, but both in Lipis and Kabul it took all of Besmelaw or Thong's pleas and threats in Farsi, Pushtu, Malay, and two dialects of Chinese to persuade. I sometimes even added tears for emphasis.

I took an American Association of Blood Banks manual to Kabul with me, and somewhere in the beginning of the book is a whole list of questions for screening donors. Well, in Asia if you turn down as potential donors anyone who has ever had malaria, TB, or "jaundice," forget it: you're just not going to get any blood. Obviously we wasted little time on considerations like whether they had had a tooth extracted in the previous week. We did take Hgb's to protect the donor. I ran VDRL's, but usually the blood was already transfused before the serology was done. (Very few positive STS.).

In Malaysia, government workers got two to three days off work for donating blood and we threw in a supply of iron pills and choice of coffee

or ovaltine, beer, or Guinness stout. In Kabul we served tea and cookies. You have all been in the Blood Bank of Hawaii donor room—so clean and quiet, with piped-in music by Muzak and paintings on the ceiling of people walking serenely into the sunset. In Lipis we used the surgery anteroom which served as surgery office, surgeon's changing room, examination room for surgery outpatients, and Medico gathering place. It was closet size, always hot, and filled with cigarette smoke and ether fumes, if the door opened during surgery—which it did frequently. When you considered the noise, confusion, lack of ventilation, and occasional appearance of the surgeon with a well-bloodied gown and full of gory shop talk, and then considered the fact that the donor was scared to death at the idea of giving blood in the first place, the amazing thing is that we had only two or three fainting donors in the year I was there. In Kabul we had a good donor room (a corner of the lab) but greater difficulties in getting donors.

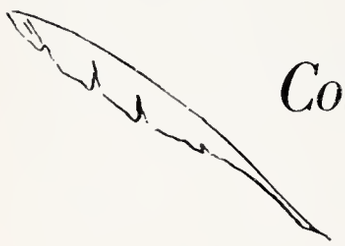
If the relatives refused to donate but were willing to buy blood (about $20 a pint, and this is an economy which pays a tech a similar amount for one month's work), then we would send Habib, the cleanup boy, down to the Bazaar to find blood donors, and he would come back with two or three Huzaras (the remnants of Ghengis Khan's invasion, looked down upon by most Afghanis because of the menial labor they perform) wearing layers of tattered coats and shirts which protect their backs from the heavy loads they carry.

There were other problems: having only empty bottles to start with and making up my own ACD solution (definitely not my idea but at the doctor's insistence). Then there was the day a man came running into the lab holding a half-emptied unit of blood with transfusion set attached and shouting "you gave the wrong blood." When I recovered enough to grab the bottle and check the name tag and number with the erossmatch book and ascertain it was the unit I had erossed, I raced upstairs to find the patient sitting up in bed and chatting with a room full of visitors. The explanation: the man had donated blood for his brother, the patient, and he saw me write "B" on the bottle. The bottle that was being transfused into his brother had an "O" on it and a different number too, so—"wrong blood!" He had expected his very own blood would be given his brother. The patient, of course, was blood group O.

And finally there was the boy who came in for elective surgery. The Medico surgeon had suggested auto-transfusions as a way of having blood available for surgery. We could not wait the week or two that is customary in the United States between phlebotomy and surgery but usually there was a three-day interval (some of these men had Hgbs of 17–19 gms.). So we had taken this particular boy's blood, and then the day before surgery he and his relatives decided against the operation and he was discharged. But before leaving the hospital they stopped in the lab to demand the bottle to take out with them. After some heated discussion and with the doctor's o.k. we gave it to them. What they did with it I will never know. ■

CAROLYNE MCCUE, MT(ASCP)

---



# *Correspondence*

## Reppun: David? or Goliath?

TO THE EDITOR:

I stand, head bloodied, but unbowed!

I am also justifiably elated—to have reached the top, in being given the honor of playing David to your Goliath!

All good, clean dissent, however, and no hard feelings.

However, the unkindest cut of all was to have had my four-year-old baby, the HAGP page, totally omitted from even passing mention by Hugh Lytle in his excellent review article. He does mention items that have come and gone. Maybe it's time for my page to disappear?

With sincere aloha,

FRED REPPUN, M.D.

October 8

• *By no means! The HAGP page is no less valued for its omission from Hugh Lytle's review, or for its occasionally assuming the role of the "loyal opposition." Please stay with it! The David & Goliath comparison, however, strikes us as a singularly unfortunate one. We haven't even got a headache, so far.*—ED.

## Mahalo mai Tahiti

TO THE EDITOR:

Many thanks for your letter of August 5, concerning the sending of copies of the HMJ to the Institute here in Tahiti. This is the only place in all of French Polynesia where researchers and doctors can find bilingual scientific and medical journals. The HMJ will be a most welcome addition to the library here, since it often contains articles of mutual importance to both Hawaii and Tahiti.

The director of the Institute, Dr. Jacques Laigret, has asked me to extend his gratitude to you for this gesture. I am sure this will help to prompt cooperation and ambiance between the two areas.

Sincerely yours,

R. J. CARDINES, M.D.

11 Août ■

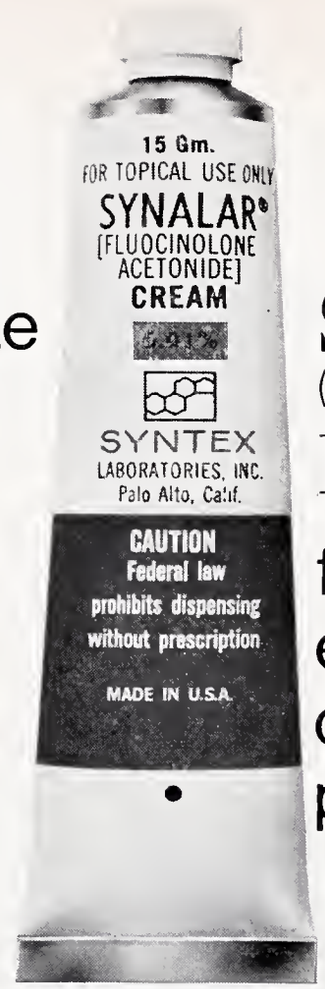
# In Hawaii . . .
# This Syntex man serves the physician



Don Wright
Orinda, California
254-3607

SYNTEX
LABORATORIES INC., PALO ALTO, CALIF

new small size




**Synalar® 0.01%**
(fluocinolone acetonide) **cream**
**15 Gm.**

for even greater economy in office or hospital practice

# the superiority of topical therapy with the

Now you can prescribe as little or as much Synalar Cream 0.01% as is needed for a particular therapeutic problem in a size that permits the greatest economy for your patient. The new 15 Gm. tube, for example, is best suited for short-term therapy and for small sites. For more extensive body areas prescribe the 45 Gm. tube—a size that's also ideal for your treatment table. And the 120 Gm. jar is most economical for hospital use. Thus, with Synalar Cream 0.01%, you have the superiority of a modern topical corticosteroid shown to be more effective than 1% hydrocortisone[1-3] plus the economy that makes therapy practical for use in more dermatologic conditions, in long-term maintenance, with occlusive dressings in resistant cases, and in extensive area involvement.

**Contraindications:** Tuberculous, fungal, and most viral lesions of the skin (including herpes simplex, vaccinia, and varicella). Not for ophthalmic use. Contraindicated in individuals with a history of hypersensitivity to any of its components. **Precautions:** 1. *General*—Synalar Cream 0.01% is virtually nonsensitizing and nonirritating. Where severe local infection or systemic infection exists, the use of systemic antibiotics should be considered, based on susceptibility testing. While topical steroids have not been reported to have an adverse effect on pregnancy, the safety of their use on pregn females has not absolutely been established. Therefore, they should not used extensively on pregnant patients, in large amounts, or for prolong periods of time. 2. *Occlusive dressing method*—With occlusion of extens areas, systemic absorption of the corticosteroid may occur, and suital precautions should be taken. Occasional patients may show contact se tivity to a particular dressing material or adhesive. Miliaria, folliculitis, pyodermas have been seen infrequently with the use of this technique. T development of infection requires appropriate antibacterial therapy and continuation of the occlusive dressing method. Local atrophy and stri have been reported with protracted occlusive dressing therapy. While lesi relapses can be expected to occur in many psoriatic patients, remissio may persist for several weeks to several months in favorable cases. T patient whose psoriasis is in an active stage, with recent appearance of n lesions, may not be a good candidate and may show early relapse. Sor plastic films may be flammable, and due care should be exercised in th use. Similarly, caution should be employed when such films are used on left near children to avoid the possibility of accidental suffocation. **Si Effects:** Side effects are not ordinarily encountered with topically appli corticosteroids. As with all drugs, however, a few patients may react un vorably to Synalar under certain conditions. **References:** 1. Cahn, M. M., a Levy, E. J.: J New Drugs 1:262 (Nov.-Dec.) 1961. 2. Meenan, F. O.: J Iri Med Ass 52:75 (Mar.) 1963. 3. Robinson, H. M., Jr., Raskin, J., and Dunsea W. J. R.: Southern Med J 56:797 (Jul.) 1963.

# of a modern corticosteroid economy of hydrocortisone

Now...a choice of 3 economical sizes




120 Gm. jar 15 Gm. tube 45 Gm. tube

fluocinolone acetonide — an original steroid from

SYNTEX

LABORATORIES INC., PALO ALTO, CALIF.

# Norinyl® tablets

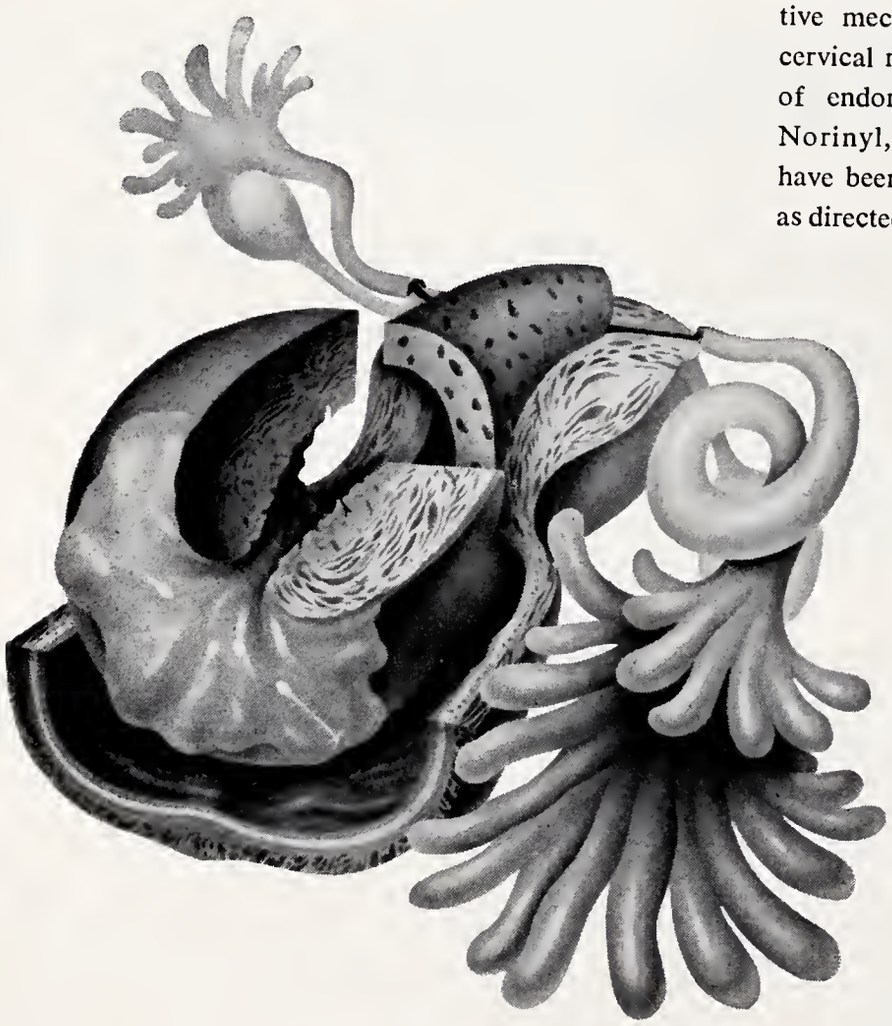
(norethindrone 2 mg. ± mestranol 0.1 mg.)

## for multiple contraceptive action that has produced a record of unexcelled effectiveness

**inhibition of ovulation by means of 2 time-proved hormonal agents**

**production of a cervical mucus hostile to sperm motility and vitality**

**creation of an endometrium unreceptive to egg implantation**



**no unplanned pregnancies**

Norinyl provides multiple action for maximum assurance of success. It does not depend on ovulation inhibition alone for contraceptive effectiveness. The mechanism of action of combined hormonal therapy results in ovulation inhibition reinforced by other protective mechanisms, including a hostile cervical mucus[1-13] and an acceleration of endometrial changes.[1-3,7-16] With Norinyl, no unplanned pregnancies have been reported to date when used as directed.

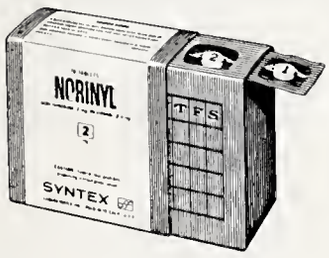
# plus important supportive benefits that help her through those critical early months of oral contraception

**low incidence of side effects**

Low incidence of BTB and spotting, nausea and amenorrhea tends to minimize side effect problems and increases patient cooperation.

**no confusion about dosage**

An unbreakable "confusionproof" package makes it easy to adhere to prescribed dosage schedule: individually sealed tablets numbered from 1 through 20 *plus* monthly calendar record enables patient to double-check dosage intake by day and corresponding tablet number.




**Contraindications:** Thrombophlebitis or pulmonary embolism (current or past). Existing evidence does not support a causal relationship between use of Norinyl and development of thromboembolism. While a study which was conducted does not resolve definitively the possible etiologic relationship between progestational agents and intravascular clotting, it tends to confirm the findings of the Ad Hoc Advisory Committee appointed by the Food and Drug Administration to review this possibility. Cardiac, renal or hepatic dysfunction. Carcinoma of the breast or genital tract. Patients with a history of psychic depression should be carefully studied and the drug discontinued if depression recurs to marked degree. Patients with a history of cerebral vascular accident.

**Warning:** Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions, medication should be withdrawn.

**Precautions:** By May 1963, experience with norethindrone 2 mg.—mestranol 0.1 mg. had extended over 24 months. Through miscalculation, omission or error in taking the recommended dosage of Norinyl, pregnancy may result. If regular menses fail to appear and treatment schedule has not been adhered to, or if patient misses two menstrual periods, possibility of pregnancy should be resolved before resuming Norinyl. If pregnancy is established, Norinyl should be discontinued during period of gestation since virilization of the female fetus has been reported with oral use of progestational agents or estrogen. When lactation is desired, withhold Norinyl until nursing needs are established. Existing uterine fibroids may increase in size. In metabolic or endocrine disorders, careful clinical preevaluation is indicated. A few patients without evidence of hyperthyroidism had elevated serum protein-bound iodine levels, which in the light of present knowledge, does not necessarily imply hyperthyroidism. Protein-bound iodine increased following estrogen administration. Bromsulphalein retention has occurred in up to 25% of patients without evidence of hepatic dysfunction. Studies from 24-hour urine collections have shown an increase in aldosterone and 17-ketosteroids and decrease in 17-hydroxycorticoid levels. Thus, Norinyl should be discontinued prior to and during thyroid, liver or adrenal function tests. Because progestational agents may cause fluid retention, conditions such as epilepsy, migraine and asthma require carcful observation. Thus far no deleterious effect on pituitary, ovarian or adrenal function has been noted; however, long-range possible effect on these and other organs must await more prolonged observation. Norinyl should be used with caution in patients with bone, renal or any disease involving calcium or phosphorus metabolism.

**Side Effects:** Intermenstrual bleeding; amenorrhea; symptoms resembling early pregnancy, such as nausea, breast engorgement or enlargement, chloasma and minor degree of fluid retention (if these should occur and patient has not strictly adhered to medication plan, she should be tested for pregnancy); weight gain; subjective complaints such as headache, dizziness, nervousness, irritability; in a few patients libido was increased. In a total of 3,090 patients, 2.2% discontinued medication because of nausea.

NOTE: See sections on contraindications and precautions for possible side effects on other organ systems.

**Dosage and Administration:** One Norinyl tablet orally for 20 days, commencing on day 5 through and including day 24 of the menstrual cycle. (Day 1 is the first day of menstrual bleeding.)

**Availability:** Dispensers of 20 and 60 tablets; bottles of 100.

**References:** 1. Council on Drugs. JAMA 187:664 (Feb. 29) 1964. 2. Brvans, F. E.: Canad Med Ass J 92:287 (Feb. 6) 1965. 3. Goldzieher, J. W.: Med Clin N Amer 48:529 (Mar.) 1964. 4. Cohen, M. R.: Paper presented at Symposium on Low-Oosage Oral Contraception, Palo Alto, Calif., July 15, 1965. Reported in Med Sci 16:26 (Nov.) 1965. 5. Hammond, O. O.: Ibid. 6. Rice-Wray, E., Goldzieher, J. W., and Aranda-Rosell, A.: Fertil Steril 14:402 (Jul.-Aug.) 1963. 7. Goldzieher, J. W., Moses, L. E., and Ellis, L. T.: JAMA 180:359 (May 5) 1962. 8. Kempers, R. O.: GP 29:88 (Jan.) 1964. 9. Tyler, E. T.: JAMA 187:562 (Feb. 22) 1964. 10. Rudel, H. W., Martinez-Manautou, J., and Maqueo-Topete, M.: Fertil Steril 16:158 (Mar.-Apr.) 1965. 11. Flowers, C. E., Jr.: N Carolina Med J 25:139 (Apr.) 1964. 12. Goldzieher, J. W.: Appl Ther 6:503 (June) 1964. 13. The Control of Fertility. Report adopted by the Committee on Human Reproduction of the American Medical Association. JAMA 194:462 (Oct. 25) 1965. 14. Flowers, C. E., Jr.: JAMA 188:1115 (June 29) 1964. 15. Merritt, R. I.: Appl Ther 6:427 (May) 1964. 16. Newland, D. O.: Paper presented at Symposium on Low-Dosage Oral Contraception, Palo Alto, Calif., July 15, 1965. Reported in Med Sci 16:26 (Nov.) 1965.

norethindrone—an original steroid from

SYNTEX

LABORATORIES INC., PALO ALTO, CALIF.

# Norinyl® tablets

(norethindrone 2 mg. c mestranol 0.1 mg.)

**for multiple contraceptive action**

## *In Memoriam* *continued from 132*

Francisco in 1901. Shortly after he accepted a position on the medical staff of the Mendocino State Hospital. For several years he was superintendent of a private sanitarium in Alameda County, California. Dr. Allen also figured as an expert witness in important criminal cases in the California courts.

On May 28, 1906, he married Kathryn Estelle Bartlett at Ukiah, California.

Entering the Army as a captain at the beginning of World War I, Dr. Allen served as a neuropsychiatrist at Letterman General Hospital in San Francisco, where he was in charge of the psychopathic wards, and at the U. S. Disciplinary Barracks at Alcatraz Island. He took part in a conference at Washington, D. C., with the Secretary of War and leading psychiatrists regarding rehabilitation plans. In 1919 he was honorably discharged with the rank of major.

Coming to Hawaii in 1920, Dr. Allen was on the staff of the Oahu Insane Asylum for two years. He then went into private practice.

In 1926 Dr. Allen left Honolulu for Little Rock, Arkansas, where he served as the medical superintendent of a Veterans' hospital.

Dr. Allen died at Little Rock on November 23, 1927, at the age of 59.

He was a member of the American Medical Association, the American Psychiatric Association, California Society for Mental Hygiene, and the Medical Society of Hawaii. He was a Mason, a Shriner, an Elk, and a member of the American Legion, San Francisco Post No. 1, the Society of Colonial Wars, the Society of Mayflower Descendants, and the Union League Club of San Francisco. ■

## *Notes and News* *continued from 137*

day, takes 14 telephone calls from patients daily, and makes hospital rounds and house calls. He treats, without charge, 400 needy patients a year, donates 100 hours a year to civic affairs, and devotes 200 hours to professional meetings and research." In addition, may we add, he is beaten up, robbed, involved in car accidents, and becomes stranded in the mountains.

In September, amiable **J. F. Moo,** proud father of the 1966 Narcissus Queen, was relaxing at a mah jongg game at a friend's home when he was threatened with an ice pick and beaten severely by two youths who forced entry into the home. In January, **Marquis E. Stevens'** home was again robbed of $2,000 worth of jewelry. (If he still has his old watch dog, we recommend a new one.) In March, **Sebron C. Culpepper's** office was robbed of $40 worth of pills and capsules. In April, **Tadao Hata's** office was robbed of $165 worth. Then in July, **Felix Lafferty's** office was robbed of more than 6,000 pills and capsules worth about $640. In August, **Keith Kuhlman's** office was robbed of three office machines, needles, syringes, and 18 bottles of pills.

In February, **Clifford Moran,** Maui Memorial Hospital pathologist, was rudely awakened when his small foreign car crashed into a military pole on Kihei Highway around 1:00 A.M. He was also injured. In March, **Clyde Ishii** of Kapaa collided with a motorcyclist traveling on the wrong side of the road without lights.

In July, **David Brown,** a Queen's intern, and two student nurses were stranded two nights in the mountains above Manoa Falls. They were spotted by helicopter and brought out by the fire department rescue team in spite of David's protests.

## Sportsmen

*Hikers:* Ambitious **Bob Wong** and his two teenage sons had programmed a two-week hiking and fishing trip in Glacier National Park. After hiking over 68 miles with his energetic sons and finding the anticipated fishing sites wiped out by floods, Bob admitted he was sore footed and exhausted.

*Surfing:* We congratulate "Hawaii Doctor" **John Roberts** for placing third in the Men 35 and Over competition of the Hawaii State Surfing Meet held at Ala Moana in August. **Robert Chung** and **Mor McCarthy** were special guests at a meeting to discuss surfing hazards to bathers on Kailua beach. Bob suggested that the boards be licensed so that parents of minors may be made financially responsible for damages by civil suits. This created some furor with the surfers present.

*Tennis:* We learned that eight doubles teams with at least 13 or 14 physician participants have been playing in "dawn's early light" on Sundays at the Ala Moana Courts. **Cal Sia** and **Hunky Chun** won the recent round robin series. We hesitate to reveal the identities of the others for fear that their sanity will be questioned.

*Golfers:* Lucky ole **Sam Yee** scored a hole-in-one at Waialae on the 173-yard second hole on a memorable September 4. Sam cringed when we asked what the drinks cost. Sam continued his streak by carding 77-9-68 next week to tie for the monthly ace. **"Toots" Fujii** and **Roy Tanoue** won the team stableford at Waialae in September and **Varian "Juicer" Sloan** captured the men's "best 17 holes" tournament at OCC on September 28 with a 79-19-60. Also in September **Duke Choy** posted a 77-9-68 in A flight to win individual medal, and **Richard Chun** and partner won team best ball with a 62. At the Ala Wai, **Wally Kawaoka** won **Diek Omura's** presidential trophy for the year by upsetting favored **Eddie Emura** in the final play-off in October. **"Slamming" Herbert Takaki** won first prize B flight while **Kyuro "Chi Chi" Okazaki** was third. **Tets Watanabe** was ninth. In A flight, **Frank Fukunaga** won the monthly trophy while **Bob Oishi** took fourth and **Yasuyuki Fukushima** fifth place.

*Fishermen:* In the middle of a Kaneohe banana patch, ten avid fishermen are building a fleet of sport fishing cruisers out of laminated fiberglass. It seems that do-it-yourselfers **Harold Sexton** and **James Cherry** are among these boat builders . . . Fisherman **Chisato Hayashi** was elected president of the Kona Casting Club for 1966-67. In his inaugural speech, Chisato pointed out that there is a great need for participation in this type of recreational pursuit "as a relief from the stresses and tempo of the times." So, even placid Kona admits its stresses. **Philip Corboy,** "long a devotee of the thrills found in tackling giant marlin and sailfish on very light gear" competed in the first annual Cabo San Lucas International Light Tackle Billfish classic held off the southern tip of Baja, California. In August, veteran fisherman **Diek Sakimoto** (who originally took up fishing to cure his ulcer) and friends made a fast overnight run to the Banks and caught 96 *opakapaka,* some *opelu* and a 35-pound *nlua,* and were back in time for work next morning. He also rid the Banks of a 100-lb. sand shark by gaffing and killing one that had been caught by a crew member.

*Football:* The HMA resolution that a physician be present at all interscholastic football games was adopted

*continued page 152*




## this part for diarrhea

**Kaolin** exerts a demulcent action along the gastrointestinal tract and a detoxifying action in the intestines to diminish irritation of the mucosa and lessen hyperperistalsis, nausea and diarrhea.

**Pectin** exerts its demulcent effect in the entire tract and its detoxifying action primarily in the large bowel to diminish irritation of the mucosa and help restore normal intestinal flora and function.

## this part for its discomforts

**Belladonna alkaloids** as in Donnatal® relieve hypermotility of smooth muscle in the gastrointestinal tract to help control cramping, nausea, and painful straining. Many clinicians consider the belladonna components of Donnagel® to be medicine's most effective depressants of intestinal motility.[1,2] A preparation containing only kaolin and pectin, on the other hand, has "little or no effect on cramps simply because it does not include an agent with antispasmodic action."[3]

# Donnagel® treats the whole diarrhea problem.

Available in new 4-ounce plastic bottle on your prescription or recommendation. Also available: Donnagel®-PG (with paregoric equivalent) and Donnagel® with Neomycin. See product literature before prescribing.

References: 1. Kramer, P., and Ingelfinger, F.J.: Med. Clin. N. Amer., *32*:1227, 1948. 2. Hock, C.W.: Clin. Med., *8*:1932, 1961. 3. Winfield, I.W.: Am. J. Gastroent., *31*:438, 1959.

A-H-ROBINS

A. H. Robins Company, Inc.
Richmond, Virginia 23220




# "CLEAR THE TRACT" WITH

# Coughing ahead...
# Clear the Respiratory Tract with Robitussin.

Much more than just a slogan, "clear the tract" reflects the dependable antitussive-expectorant action of the three Robitussin formulations. All contain glyceryl guaiacolate, the time-tested expectorant that greatly enhances the output of lower respiratory tract fluid. Increased RTF volume exerts a demulcent effect on the tracheobronchial mucosa, promotes ciliary action, and makes thick, inspissated mucus less viscid and easier to raise. Glyceryl guaiacolate is safe, non-narcotic, and almost universally accepted by patients of all ages.

| NOW! THREE ROBITUSSIN FORMULATIONS | ROBITUSSIN | ROBITUSSIN A-C | ROBITUSSIN-DM |
|---|---|---|---|
| EXPECTORANT | ● | ● | ● |
| DEMULCENT | ● | ● | ● |
| COUGH SUPPRESSANT | | ● | ● |
| ANTIHISTAMINE | | ● | |
| LONG-ACTING (6-8 hours) | | | ◐ |

FORMULAS

**ROBITUSSIN®**
in each 5 cc. teaspoonful:
Glyceryl guaiacolate 100 mg.
(Alcohol 3.5%)

**ROBITUSSIN® A-C**
*(exempt narcotic)*
in each 5 cc. teaspoonful:
Glyceryl guaiacolate 100 mg.
Pheniramine maleate 7.5 mg.
Codeine phosphate 10.0 mg.
(warning: may be habit forming)
(Alcohol 3.5%)

**ROBITUSSIN®-DM**
*new, non-narcotic*
in each 5 cc. teaspoonful:
Glyceryl guaiacolate 100 mg.
Dextromethorphan hydrobromide 15 mg.

Robitussin and Robitussin-DM are available at pharmacies everywhere on your prescription or recommendation.

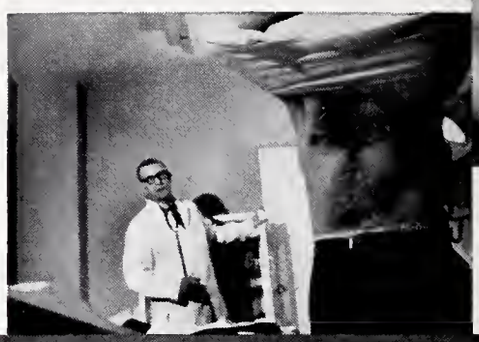
A. H. Robins Company, Inc. Richmond, Va.

OUR PHOTO:
Engine No. 89 of the Monadnock, Steamtown & Northern Railway pulls a trainload of steam enthusiasts through the New England countryside between Bellows Falls and Chester, Vermont.

A·H·ROBINS

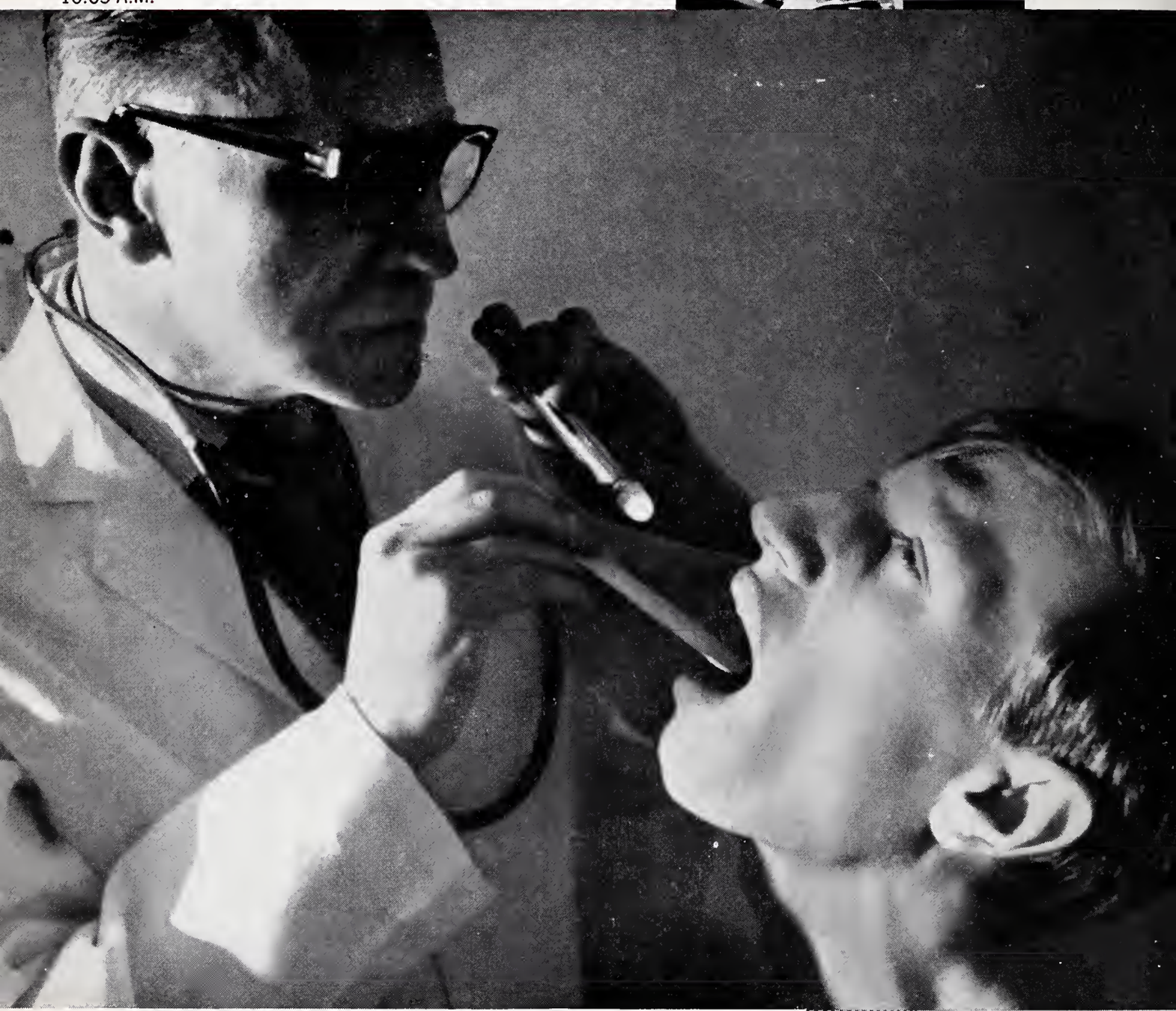
# ONE OF THE ROBITUSSIN® FORMULAS

# This is the new, everyday penicillin for common bacterial respiratory infections...



10:38 A.M.

10:05 A.M.







10:42 A.M.

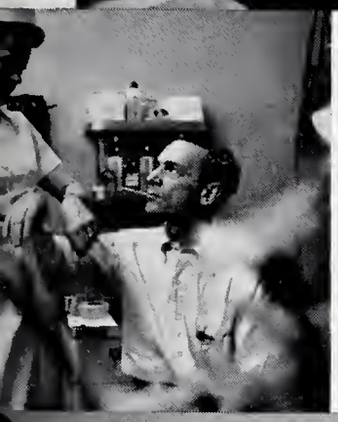
# ...the only low-cost antibiotic bactericidal against all common Gram-positive cocci



11:00 A.M.



11:20 A.M.



11:47 A.M.



12:01 P.M.

## Clinical success

Tegopen (sodium cloxacillin monohydrate) assures you a high degree of clinical success against respiratory infections. A recent comprehensive analysis of office patients administered the drug proves the point: *96% of 259 bacterial respiratory infections treated were cured or improved.*[1]

## Kills common respiratory Gram-positive cocci

In contrast to the Gram-positive spectrum of penicillins G and V, Tegopen (sodium cloxacillin monohydrate) destroys strep, pneumo and virtually *all* staphylococci.

## Bactericidal in action

Tegopen (sodium cloxacillin monohydrate) is bactericidal, killing the offending organism. Erythromycin[2] and triacetyloleandomycin[3] are essentially bacteriostatic agents which merely suppress bacterial growth.

## Minimal side effects

There is little likelihood of dose-related toxicity with Tegopen (sodium cloxacillin monohydrate).

## Low in cost

Even with all of its extra advantages, Tegopen (sodium cloxacillin monohydrate) is priced competitively to brand name general purpose penicillins, and 33% less than either erythromycin or triacetyloleandomycin.

BRISTOL THERAPEUTIC SUMMARY: For complete information, consult Official Package Circular. *Indications:* Infections due to streptococci, pneumococci and staphylococci, particularly penicillin G-resistant strains of the latter. *Contraindications:* A history of severe allergic reactions to penicillins. *Precautions:* Typical penicillin-allergic reactions may occur, particularly in hypersensitive persons. Mycotic or bacterial infections may occur. Safety for use in pregnancy is not established. Assess renal, hematopoietic and hepatic function periodically during long-term therapy. *Adverse Reactions:* Nausea, epigastric discomfort, flatulence, diarrhea, eosinophilia, and allergic manifestations. Moderate SGOT elevations have been noted. *Usual Dosage:* Adults: 250 mg. *q.* 6 *h.* Children: 50 mg./Kg./day. Children weighing more than 20 Kg. should be given the adult dose. Treat beta-hemolytic streptococcal infections for at least 10 days. Administer 1 to 2 hours before meals. *References:* 1. Data on file at Bristol Laboratories. 2. Geraci, J.E. (Panel Discussion, M. Finland, Moderator): Antibiot. Ann. 1958–59: 1051, 1959. 3. Thompson, W.T., Jr.: South. M. J. *56*:844 (Aug.) 1963.

BRISTOL LABORATORIES
Division of Bristol-Myers Co., Syracuse, New York

**IN TONSILLITIS · PHARYNGITIS · OTITIS MEDIA · SINUSITIS · BRONCHITIS · PNEUMONITIS**

1:15 P.M.

# new TegoPen®

SODIUM CLOXACILLIN MONOHYDRATE

by the Board of Education. **Dick Ando,** Board chairman, emphasized the devotion of these team physicians by pointing out that the Oahu League physicians are given small honorariums which they usually give back to the teams for year-end parties. **Fred Reppun** wrote to the commissioner of the Pop Warner League recommending that the young kids in Pop Warner League not be burdened with shoes and that they should revert to the traditional barefoot football that was once famous in Hawaii. Fred feels, "If we go barefoot, not only will it be a safer sport in our Hawaiian turf, but it will be faster football and save the clubs and the parents a pile of money." Smart fellah, this Fred.

## Health Department

We studied the Health Department's constant stream of health information with consuming interest: Early in July **Ralph Berry,** our state epidemiologist, cautioned that syphilis cases in Hawaii during the past 12 months increased 81 per cent over the previous year. There were 38 cases reported between July 1, 1964 and July 1, 1965 while 61 cases were reported this year. In late July, Ralph announced that the outbreak of typhoid fever (consisting of four cases which occurred in June) was under control. All the victims had attended a large family party and had become ill within the usual two-to-four week incubation period. Ralph added, "We do not expect any more cases of typhoid fever as a result of this exposure. However, we will continue our intensive investigation to find persons who may have become infected without developing symptoms." In August, Ralph was again mounted on his white charger and pushing measles vaccination. "If measles can be stopped among school children, babies will be safe until between nine months and one year of age which is the most common time for them to be vaccinated. Any child over one year and under school age should be vaccinated."

**F. H. Tong,** Maui district health officer, launched a $5,000 Anti-Rat Campaign. An emergency control appropriation was made to prevent a recurrence of last year's epidemic during which residents claimed that "even the cats are so full of the rodents that they refused to even look at them any more." Poor F. H., he has his rodent and mosquito problems.

On Kauai, health officer **Peter Kim** warned swimmers of the Portuguese Man of War (Physalia) paying their annual summer visit to Hawaiian shores.

We were happy to see **Louise Childs** return with her Master's degree in Public Health from the University of California. She was appointed chief of the Maternal and Child Health Branch. We have noticed that Edgar looks better fed since her return.

**Arnold Schwartz,** a California psychiatrist-administrator who emphasizes the "humane approach" to mental health, has been named to head Hawaii's rapidly expanding community health center programs. Arnold favors "mental health promotion," and cites seat belts as a typical example. "They have everything to do with mental health if you look at it." Take for example, a husband who is driving and his wife in the seat beside him is killed in a wreck because she doesn't have her seat belt fastened . . . The husband suffers guilt feelings because he is still alive . . . The children's home is broken . . . What situation could be more damaging to the mental health of people involved . . ." Now when you put it that way.

## Doctors in Print

We congratulate the following for their contributions to medical literature: **D. R. Bassett** for his article, "Serum Uric Acid and Obesity in Hawaiians" *JAMA* 196:152-153 (Apr. 25) 1966; **Eldon Dykes** for "Plastic Surgical Management of Congenital Anomalies" *Birth Defects—Abstracts of Selected Articles* April 1966; **J. E. Strode** for "Congenital Cystic Dilatation of the Common Bile Duct" *International Surgery* V. 45, #5 Section I May 1966; **Robert A. Nordyke** for "Screening Test for Thyrotoxicosis" *Modern Medicine* July 18, 1966; **Richard K. Blaisdell,** "Red Cell Production and Survival" *Anesthesiology* July-Aug. 1966; and **Walton K. T. Shim,** "Treatment of Congenital Megacolon in 50 Infants." *Pediatrics,* 38: 185-193 (Aug.) 1966.

## Members Speak Up

HMA Prexy **Ted Tomita** wrote a straightforward, matter-of-fact Letter to the Editor which is reproduced here in toto: "Some one wrote objecting to the FDA suggestion for control of vitamins. The Surgeon General has said that even the adolescent diet has ample vitamins necessary for health. He said that people who dose themselves with vitamins are wasting their money. Millions of dollars are spent needlessly. Only in rare instances are vitamins actually required. In that case, a physician is the proper person to prescribe them after a physical examination. The position of the FDA is that money would be better spent for food than for a diet supplement useless to 99 per cent of the people.

By the way, the body stores up vitamins and they have sometimes been found harmful to people who overdose themselves. There are cases of hypervitaminosis A&D.

New regulations are being formulated which will curtain the addition of these vitamins to processed foods."

Alas, the reaction was humorous and astonishing. It shows that either people cannot read, that they are afraid to admit they are dupes of vitamin ads or that the public image of the physician still leaves much to be desired.

"Body Beautiful" Rex Ravelle, President of the Physical Culture Association of Hawaii, wrote knowledgeably that "overconsumption of foods, alcohol, aspirin, salt, sugar, tobacco, and so on could be disastrous too." He then added that "there is no justifiable excuse for government edicts requiring vitamins and minerals be controlled or prescribed by doctors."

A Patricia Bragg, Graduate Bio-chemist and Nutritionist wrote: "I wish to take issue with the doctor who would require prescriptions for harmless vitamin supplements." She also added, "I dare the doctor to produce one documented case in the literature of vitamins where anyone has been harmed by taking simple vitamins." (We wonder how she ever graduated as a biochemist and nutritionist.)

A Fred Van Dyke accused Ted of saying that *all* vitamins should be by prescription and that the FDA was going to push a law through which free choice of vitamins will be prohibited. Another who signed himself H. S., who apparently does not know the difference between Surgeon General and Attorney General, wrote, "It's none of the Attorney General's business if I want to buy vitamin C nor should it be any business of my doctor, the HMA or the AMA . . ."

Pediatrician **Edward C. Wo Lum** is to be congratulated for criticizing the deplorable conditions at the Palolo Chinese Men's Home. He says, "We have child-abuse laws. What about aged-abuse laws?" We sincerely hope his report to the Honolulu Council of Social Agencies will bring some necessary changes.

When Sparky Matsunaga labeled Francis Aki's campaign for peace in Viet Nam "no more than a publicity stunt," **Bill Meyer's** dander was up. Bill, in a letter to the editor, deplored the horrors of war in Viet Nam and added, "Tell that to the wives and mothers of the boys who are dying in Viet Nam, Mr. Matsunaga, and to the taxpayers who are picking up the tab of over 60 million dollars a day."

**George Goto,** Chairman of Doctors for Sparky Committee retorted, "I am in complete agreement with the

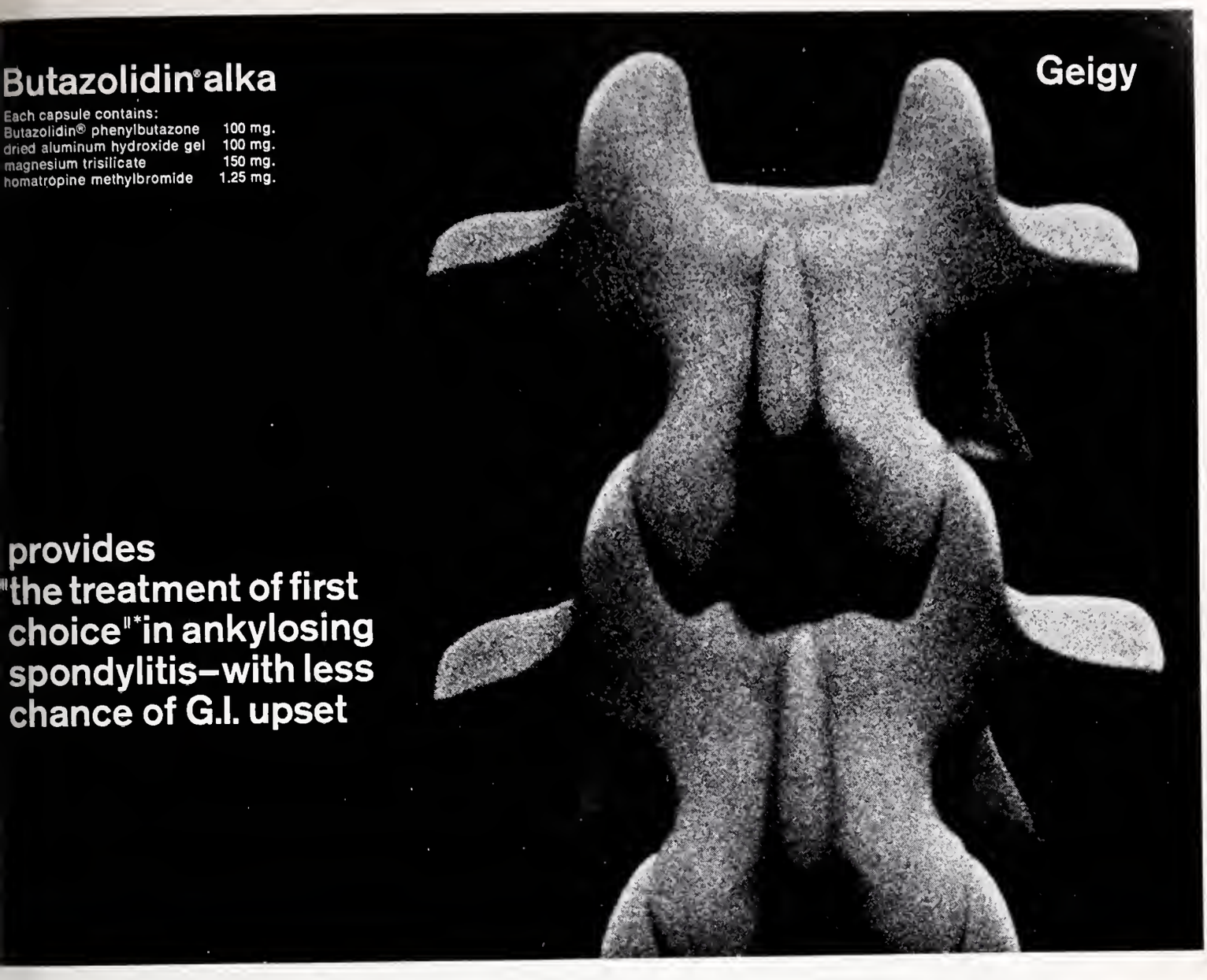
*continued page 154*

# Butazolidin® alka

Each capsule contains:

| | |
|---|---|
| Butazolidin® phenylbutazone | 100 mg. |
| dried aluminum hydroxide gel | 100 mg. |
| magnesium trisilicate | 150 mg. |
| homatropine methylbromide | 1.25 mg. |

Geigy



## provides "the treatment of first choice"* in ankylosing spondylitis—with less chance of G.I. upset

Most investigators report excellent results with phenylbutazone, and many consider it the drug of choice. Their studies indicate that 70-90% of patients experience substantial improvement. And Butazolidin alka combines phenylbutazone with antacids and an antispasmodic to minimize chances of G.I. upset.

Improvement is usually prompt, depending on the degree of fibrosis and calcification. In most cases, after 2 or 3 days there is less pain, stiffness and muscle spasm, increased mobility of the back, and increased chest expansion. Maintenance dosage may be as low as 100 to 200 mg. daily. And the trial period is only 7 days.

**Contraindications**
Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. Because of the increased possibility of toxic reactions, the drug should be used with greater care in the elderly and should not be given when the patient is senile or when other potent chemotherapeutic agents are given concurrently. Large doses of Butazolidin alka are contraindicated in patients with glaucoma.

**Warning**
If coumarin-type anticoagulants are given simultaneously, the physician should watch for excessive increase in prothrombin time. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Patients receiving such concomitant therapy should be carefully observed for this effect.

Use with caution in the first trimester of pregnancy.

**Precautions**
Before prescribing, the physician should obtain a detailed history and perform a complete physical and laboratory examination, including a blood count. The patient should be kept under close supervision and should be warned to report immediately fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools. Regular blood counts should be made to guard against blood dyscrasias.

**Adverse Reactions**
The most common adverse reactions are nausea, edema and drug rash. Moderately lowered red cell count may sometimes occur due to hemodilution. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. Infrequently, agranulocytosis, exfoliative dermatitis, Stevens-Johnson syndrome or a generalized allergic reaction may occur and require withdrawal of medication. Stomatitis, salivary gland enlargement, vertigo or languor may occur. Leukemia and leukemoid reactions have been reported but cannot definitely be attributed to the drug. Thrombocytopenic purpura and aplastic anemia are also possible side effects.

Confusional states, hyperglycemia, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hepatitis, jaundice and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently.

For complete details, please refer to full prescribing information. 6509-V(B)

**Average Dosage in Rheumatoid Spondylitis**
Initially, give 400 mg. daily (one capsule q.i.d.), reducing this, if possible, when a favorable therapeutic effect has been obtained. If after one week there has been no response, discontinue the drug.

**Also available:**
Butazolidin, phenylbutazone
Tablets of 100 mg.

*Kuzell, W. C.: Presented at the Clinical Session of the American Medical Association, Philadelphia, November 30, 1965.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York

BU-3806P

## *Notes and News* *continued from 152*

horrors of war described by Dr. William Meyer regarding the present Viet Nam conflict. His conclusions, however, appear to be misdirected"... "I do not consider Congressman Matsunaga's communication to Mr. Aki as being improper. As a matter of fact, creating a political football out of the Viet Nam war as Mr. Aki is attempting to do will do grave injustice and inflict genuine heartaches to the wives and mothers whose husbands and sons have given their lives for this country." The essence of *yawara* (a form of Judo) is to topple an opponent by using his own force. George seems to be a master of this art.

A conscientious school teacher asked **Harry Arnold, Sr.,** whether or not the periwinkle which is so common in Hawaii was a dangerous plant since she had read that it contained a substance that was very poisonous and was used in the treatment of leukemia and other types of cancer. Harry, Sr., checked with Eli Lilly which manufactures the substance and learned that it would be necessary for a child weighing 50 lbs. to eat at least 20,000 leaves before any poisonous action would be observable. He added, probably with a twinkle in his eye, "so let's all continue to enjoy the flowers of the periwinkle."

We noticed this short news item: **"Dr. Richard You,** physician and sportsman, yesterday said that he has decided against running for political office this year, but may be a candidate in the future." ■

---

## *Hawaii Medical Association* *continued from 138*

**these affirmations to all hospital administrators and chiefs of staff.**

***Plantation Physicians:*** The plantation physicians are asking for support and direction from the HMA Council re practice of medicine by corporations.

**ACTION:**

**It was voted that the Council reaffirm the AMA Report of the Judicial Council re contract practice, and to urge the county medical societies to review all contracts with plantations existing in their counties and take appropriate action.**

**It was also voted that the HMA direct an appropriate committee to work with the HSPA and the unions towards securing free choice of physicians and the concept of fee for service for plantation personnel.**

**ACTION:**

**It was voted to approve the following resolution and to inform HEW that plantation doctors should be paid on a fee-for-service basis with free choice of physician.**

***Resolution re Practice of Medicine by Corporations:***

WHEREAS, It is illegal for corporations to practice medicine according to the Hawaii State Law; and

WHEREAS, Such practice is detrimental to the best interests of scientific medicine and of the people themselves according to the AMA Judicial Council; and

WHEREAS, The greatest incentive to scientific improvement will be destroyed and the public will be poorly served; now therefore be it

*Resolved,* That the Hawaii Medical Association go on record in support of free choice of physician for plantation pensioners covered under Medicare.

***Department of Health:*** The Negotiating Committee is meeting to establish a schedule which will be presented to the Department of Health. The Plan is to ask for a 5.0 conversion factor for all sections of the 1965 Hawaii RVS and to request that physicians servicing clinics be paid on a fee-for-service-basis, using that section of medicine entitled "consultations" when applicable.

The DSS has been advised of the wishes of HMA as mentioned above.

**ACTION:**

**It was voted that the Council reaffirm the action of the Negotiating Committee.**

***Hospital Based Physicians:*** The radiologists have not yet completed the survey of types of contracts which their members now have with hospitals. The pathologists advised as follows:

To the best of my knowledge, at the present time, the pathologist-hospital contractural arrangements are quite varied, and are as follows: There is a percentage type of remuneration at three Oahu hospitals (Kuakini, St. Francis, and Children's); four other hospital pathologists are on salary (Kaiser, Kapiolani, Castle, Wahiawa); Queen's Hospital is on a mixed arrangement in which the pathologists separately bill for tissues but are given a set remuneration by the hospital for clinical and autopsy material. On the outer islands, one pathologist is on straight salary (Hawaii) and the other two (Maui and Kauai) are on a mixed salary-plus billing arrangement. The procedure for billing is completely separate from the hospital billing and independent facilities are used for this billing on Oahu and Maui. The procedure on Kauai may be through the hospital.

The Council was advised that effective September 1, 1966, the radiologists at St. Francis Hospital will be submitting separate bills for all patients.

It was recommended that the Honolulu County Medical Society be advised that Kuakini Hospital pathologists and radiologists have not conformed to the resolution re Hospital Based Physicians as approved by the HMA House of Delegates. It was also recommended that letters be sent to the Board of Trustees of the neighbor island hospitals.

***Workmen's Compensation:*** The Workmen's Compensation Committee feels that it is important to reach an understanding with those people who ordinarily oppose the physicians' requests for equitable fees. In order to help bring this about, the committee would like to entertain representatives of insurance and management at a dinner. Permission is requested for funds for this activity.

**ACTION:**

**It was voted to approve the request of the Workmen's Compensation Committee for a dinner meeting with representatives of insurance and management. It was suggested that if the next schedule does not in fact reflect the going rate in the community, that the HMA should institute legal action.**

**ACTION:**

**It was voted for the Workmen's Compensation Committee to institute legal action if the fee schedule does not reflect the going rate in the community.**

***HMSA Negotiations:*** The last official letter sent to HMSA went to the President, Mr. Chatterton, on June 3, 1966. Since that time the only communication received has been a copy of a letter Mr. Chatterton wrote to Mr. Paul G. Pinsky (labor insurance specialist) on July 13, 1966. In Mr. Chatterton's letter to Dr. Tomita dated May 24, 1966 he stated "I will be in touch with you to establish a date for our first meeting with whatever individuals you designate. It is our hope that we may deal with some fresh faces and to that end it is suggested that initially the officers of HMA and the officers of HMSA make up the discussion teams."

Dr. Tomita's June 3 reply to Mr. Chatterton was as follows: "The membership has on a number of occasions given a vote of confidence to the Negotiating Committee which has worked on the HMSA contract, and I have reappointed these men to continue to serve in this capacity. I would not only be remiss in my duty if I did not do this, I would be ignoring the wishes of the mem-

*continued page 158*

# THREE TIMES A YEAR

*Your patients without a plan to economically protect them when they are in need of medical assistance may join Hawaii's own community service medical plan on an individual basis three times a year.*

*Membership is open to qualified individuals of all ages in*

MARCH — JULY — *and* — NOVEMBER

*HMSA is a non-profit, community service organization. As such it is able to provide tremendous benefits for reasonably low dues.*

*HMSA is the medical plan which gives you free choice of doctors and hospitals — an extremely desirable feature.*

Member of Western Conference of Prepaid Medical Service Plans




® BLUE SHIELD PLAN FOR HAWAII

## HAWAII MEDICAL SERVICE ASSOCIATION

*For More than 28 Years — Hawaii's Own / Hawaii Owned*

# This new hypoallergenic formula is like a milk formula in many ways...





## Looks, mixes, pours and is accepted like a milk formula

New ProSobee provides a creamy-white hypoallergenic formula that makes the transition from a cow's-milk formula smoother and less troublesome than ever before. ProSobee mixes and pours like milk-based formula, and to all outward appearances seems just like a routine formula. There is no coffee color...no "beany" aroma or flavor...no nipple-clogging coarseness.

ProSobec formula utilizes a unique soy-protein isolate which eliminates all the disturbing physical negatives associated with most soy formulas. A mother's unfavorable reaction to the look and smell of a soybean formula could be easily communicated to a sensitive infant. Milk-like ProSobee formula helps keep feeding time the natural, pleasant experience it should be.

## Stool patterns and nutritional values like a milk formula

The stool patterns of infants on ProSobee resemble those of infants on routine milk formulas. There is no offensive odor, no tendency to looseness, no suspicious staining of diapers. Nothing to alarm or disturb the mother...nothing to motivate time-consuming phone calls.

Weight gains obtained with ProSobee formula are comparable to normal gains for infants on cow's-milk formulas. Its protein efficiency value closely approaches that of casein, and is significantly higher than values found in whole soy flour formula. A recent study,* moreover, showed that only ProSobee formula was *devoid of antigenicity,* when compared with two commercially available soybean infant formulas.

*Crawford, L.V., *et al.:* Ann. Allergy *23*:303 (July) 1965.

PROSOBEE IS A TRADEMARK OF MEAD JOHNSON & COMPANY.
©1966, MEAD JOHNSON & COMPANY, EVANSVILLE, INDIANA.

**ProSobee®**

MILK-FREE FORMULA WITH SOY ISOLATE

## *Hawaii Medical Assn.* *continued from 154*

bership. While I have the authority to appoint all committees, I must continue to be guided by the wishes of those who have placed their confidence in me by electing me to the presidency of the HMA."

**ACTION:**

**It was voted to commend the President in reappointing the Negotiating Committee and that the Council back the President in maintaining the same members of the Negotiating Committee.**

***VA Contract:*** The Council was advised that if any changes are to be made in the VA Contract, that they must be submitted by September 15, 1966. It was felt that no change should be requested at this time.

***Staff Salaries:*** The President reported on the salary structure of HMA staff members and recommended that the administrative assistant and clerical and stenographic staff receive substantial increases.

**ACTION:**

**The salary increases as recommended were approved.**

The meeting adjourned at 12:15 A.M. ■

R. VARIAN SLOAN, M.D.
*Secretary*

## *Book Reviews* *continued from 133*

this volume, he has outdone himself. Endocrinology is, at best, still in a nebulous developmental stage, yet with the guiding influences of editors Ernst Oppenheimer and Peter Forsham, and the many outstanding consultants and contributors, the author has produced a master volume which combines the most recent available information with the basic fundamentals so that any inquiring physician can have his questions answered without tedious research. As can be gathered from the title, the volume covers not only the endocrine glands, but all the basic related subjects, such as carbohydrate, protein and fat metabolism: the major vitamins; enzyme chemistry, and genetics and inborn metabolic errors, in a concise and clear presentation which is augmented with those precious, simple, graphic illustrations so characteristic of Frank Netter. Perhaps the author's greatest contribution to medical reading is that he takes out the tedium and turns it to pure and simple pleasure.

HENRY YOKOYAMA, M.D.

### ★The Differential Diagnosis of Cardiovascular Diseases

*By Aldo A. Luisada, M.D., and Sheldon J. Slodki, M.D., 226 pp., $9.75, Grune and Stratton, 1965.*

THIS BOOK is written authoritatively, clearly, and with a minimum of excess verbiage. The format is simple, with the authors wisely dividing the subject matter into three large subdivisions according to the periods of physical development.

The text is, within its limits, comprehensive, in that not only disease states but also many normal physical and laboratory findings which may be misinterpreted as indicating cardiovascular diseases, are discussed. The discussion is limited to specific salient symptoms, physical findings of note, and pertinent laboratory data only. No attempt is made to cover the gamut of clinical information available. Unfortunately there are few tables, but these are excellent, and in turn are their own best advocate for more. I highly recommend this book for all busy clinicians.

BERNARD W. D. FONG, M.D.

### Disorders of Carbohydrate Metabolism in Infancy

*By Marvin Cornblath, M.D., and Robert Schwartz, M.D., 297 pp., $8.50, W. B. Saunders Company, 1966.*

THIS EXCELLENT CURRENT summary stresses clinical understanding of these metabolic disorders. It is written relatively simply and does not go into very minute biochemical details. Clinical pathophysiology is emphasized, and clinicians caring for newborns and infants will find this book a handy and practical reference in the recognition, understanding, and treatment of these disorders.

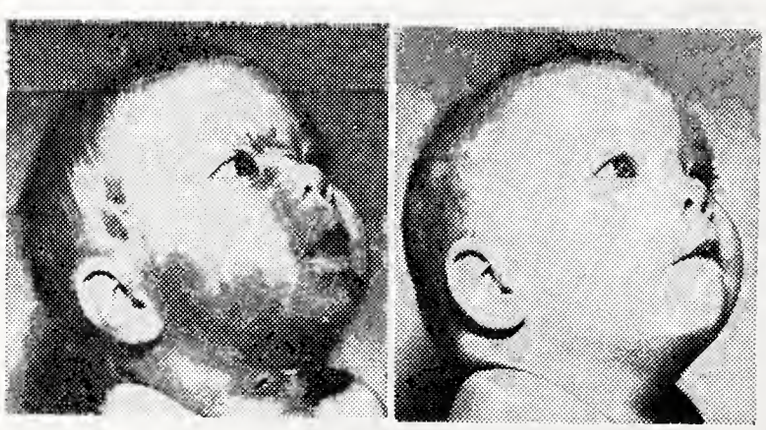
It is certainly recommended reading for pediatricians and general practitioners especially.

HIROAKI TOTTORI, M.D.

### Surgery of the Foot, 2d Ed.

*By Henri L. DuVries, B.S., D.S.C., M.D., in collaboration with the members of the Faculty of the University of California School of Medicine, San Francisco, Foreword by Verne T. Inman, A.B., M.A., Ph.D., M.D., 586 pp., $17.50, The C. V. Mosby Company, 1965.*

DR. DUVRIES and the publishers should take pride in the format, printing, diagrams, illustrations, and outstanding x-ray reproductions, which are a veritable museum of pathology. As for the text itself, it would be nice to know for whom the book is written. The chapters on infections, ulcers, tumors, disorders of the skin, toe nails, synovia, fascia, tendons, and sesamoids as well as

**BLEMISHES?**

COVERMARK conceals all skin discolorations . . . birthmarks, brown & white patches, broken veins, tattoos, burns, scars, on any part of the body. COVERMARK is also unexcelled as an overall makeup . . . will not rub or flake off. Waterproof and Sunproof.

*Lydia O'Leary*
**OF HAWAII**
ALA MOANA CENTER—STREET LEVEL
PHONE 993-288

aseptic necrosis and epiphysitis all should appeal primarily to the generalist. Even at this, there are grave omissions. Such a relatively fundamental concept as immobilization of the limb in a short-leg walking cast should at least be mentioned following extensive soft tissue surgery. The suggestion that passive exercises and massage after cast removal is good treatment is a dated concept, and a practice which should long ago have been discarded. Some of the classifications are obviously contrived and only complicate the subject matter. Far too much reliance is placed upon surgical procedures in therapy and far too little attention is paid to the importance of good foot care and proper shoe wear.

For the specialists, Drs. Dickson and Jackson's chapter on fractures and dislocations is excellent. It is concise and practical. Other chapters, on static deformities, major deformities and congenital abnormalities are adequate for the specialists but not overly complete and may be of benefit to a generalist interested in this area.

While the book has a number of interesting ideas and is complete in a sense, it also is incomplete and cannot be considered an effective reference book.

This book, then, does not fill the need for which I believe the author intended it, a comprehensive document on the foot. Instead it is directed to a number of groups and in too many instances passes on to us many dated and poorly documented ideas rehashed from an age of medical subjectivism.

LAWRENCE H. GORDON, M.D.

### ★Progress in Medical Genetics, Vol. IV

*Edited by Arthur G. Steinberg, Ph.D., and Alexander G. Bearn, M.D., 280 pp., $12.75, Grune & Stratton, 1965.*

THIS ANNUAL review of medical genetics has been a worthwhile addition to the medical library. Volume IV is highly recommended.

The first chapter, on disorders of the thymus and other lymphoid tissues, would be of interest to all practicing physicians. It is well written, concise, and surprisingly easy to comprehend. It is not mixed with technical jargon which would be understood only by the most specialized research worker.

The other chapters are more specialized. Clinicians who are interested in genetics would find them interesting. A good treatise on the lactic dehydrogenase (LDH) isozymes has been presented.

NOBORU OISHI, M.D.

### Fundamentals of Internal Medicine: A Physiologic and Clinical Approach to Disease, 3rd Ed.

*By Robert P. McCombs, B.S., M.D., F.A.C.P., 845 pp., $13.00, Year Book Medical Publishers, Inc., 1965.*

THIS TEXT by Dr. McCombs is an easily readable if somewhat superficial treatise on the diseases confronting internists. However, this very superficiality makes it difficult to determine what its place is among the available textbooks covering these diseases. Any book which covers such poorly understood conditions as glycogen storage disease, Marfan's syndrome, hemochromatosis, and familial Mediterranean fever in the space of a few pages, allowing a little more than one paragraph for each disease, can hardly be considered a reference text. Its easy readability does lend itself to a rapid review of the vast field of internal medicine; however, such rapid and superficial reviews are not, in this reviewer's opinion, what most internists are looking for.

The book is attractive, has large print which is easily read, and is equipped with a very adequate index.

M. G. BOTTICELLI, M.D.

*continued page 160*



## *Doctor's Wallet*



L2-11

Holds money, prescription pad, doctor's cards and his own pen or pencil in a finely crafted imported English Morocco case. BLACK OR BROWN.

**$10.00 EACH—2 FOR $18.00**

Add 50¢ Postage and Handling
NO C.O.D.

**BENTLEY SALES**
821 Market Street
San Francisco, Calif. 94103


*Book Reviews continued from 159*

### ★Comparative Basic Cardiology

*By Jane Sands Robb, M.D., Sc.D., 602 pp., $39.00, Grune & Stratton, 1965.*

THIS FASCINATING volume is crammed with information concerning the embryology, anatomy, histology, histochemical studies, and the electrophysiology of the heart as related to the animal kingdom. A large portion of the text is devoted to the atrioventricular system, the particular area of interest of the author. The volume is profusely illustrated with color plates, line drawings, and schematics, all of which add clarity to the meaty text. Quotations are freely used, making the text a mixture of many literary styles, which in turn heightens readability. This is an invaluable reference work, particularly to those engaged in the investigative basic sciences, and to a limited extent to those teaching in this area.

BERNARD W. D. FONG, M.D.

### ★Clinical Anticoagulant Therapy

*By I. Myron Vigran, M.D., M.S. (In Med.), with collaborating authors and a foreword by Irving S. Wright, 315 pp., $15.00, Lea & Febiger, 1965.*

THIS BOOK is a worthwhile reference to have on any practitioner's shelf. The author's aim is well accomplished in this well-organized and clearly written book. Anticoagulant therapy management and its complications and contraindications are very well and thoroughly covered.

For those who are interested in reviewing blood coagulation, the book contains a concise and short review with a fairly good summation of the various clinical

*continued page 162*


CONSIDERING
CONTACT LENSES?

*Here's Good News!*

Newly perfected Micro thin lenses now provide:

- Shorter fitting time
- Greater comfort
- Reduced period of adjustment to lenses

We continue to offer highest quality and finest service for all your optical requirements.

GUILD OPTICIANS
**OPTICAL DISPENSERS**
**of Hawaii, Inc.**

*Additional location at:*

**1133 BISHOP ST.** **576-570**
**312 ALA MOANA BLDG.** **976-925**



**MEDICAL PLACEMENT BUREAU**
**and**
**NURSES' REGISTRY**

24 HOUR SERVICE

**LET US SERVE YOU IN YOUR NEED**

Nurses, Staff and Office
Nurses, Private Duty
Nurses, Supervisors
Practical Nurses
Nurses, Aide
Dental Assistants
Physical Therapists
X-Ray Technicians
Laboratory Technicians
Medical Stenographers
Medical Clerks
Receptionists
Male Nurses
Bookkeepers
Home Companions

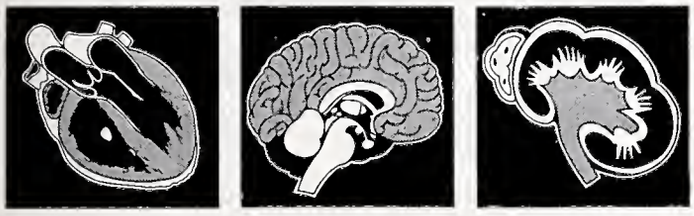
Frieda M. Beezley, R.N., *Director*
Patsy Harrison, *Secretary*

**1473 South King St.** **991-237**

# *Behind continued high blood pressure readings lies the possibility of organic damage*[1-13]

MANY OF THE aspects of essential hypertension are unpredictable—either because there are a number of mechanisms involved or because individuals differ in their responses to these mechanisms.[1]

There is one aspect of hypertension, however, that seems, in many cases, predictable. ". . . when the blood pressure is elevated to a marked degree for an adequate period of time, this in itself leads to perpetuation of the syndrome with resulting vascular damage throughout the body."[14] All too often the disease progresses until there is damage to one of three vital organs: the heart, the kidney, the brain.



"Hypertension is certainly a major factor in the genesis of coronary heart disease, and it is even more important when compounded with obesity."[4]

"[Vascular deterioration] can be clearly seen in the kidney with a degree of damage that can be measured by renal function studies."[10]

". . . most evidence suggests that reduction of blood pressure, when it is too high, not only relieves the heart of excess work but reduces vascular damage."[1]

**"In short, treatment is indicated."[1]**

Antihypertensive therapy will not restore the blood vessels to normal. Yet many of the vascular changes and symptoms caused by increased blood pressure may be arrested or alleviated when the blood pressure is reduced to normotensive levels.[7]

Reducing the blood pressure helps curtail further vascular damage and improves the prognosis — when damage is not too far advanced before therapy is started.[14] Essential hypertension is an indication not only for treatment, but for *early* and adequate treatment of the patient in question.

**Reduce the blood pressure with Rautrax-N**

Rautrax-N combines the antihypertensive-tranquilizing action of whole root rauwolfia with the antihypertensive-diuretic action of bendroflumethiazide in one convenient medication. The two drugs complement each other so that smaller doses of both are possible.

Rauwolfia combined with bendroflumethiazide is particularly effective in long-term therapy,[15-17] since beneficial effects do not diminish with continuous daily administration.

For most patients 1 or 2 Rautrax-N tablets daily are sufficient for maintenance therapy. The simplicity, convenience and economy of such a dosage schedule are of particular benefit to older patients.

**References:** 1. Page, I. H., and Dustan, H. P.: The Usefulness of Drugs in the Treatment of Hypertension, in Ingelfinger, F. J.; Relman, A. S., and Finland, M.: Controversy in Internal Medicine, Philadelphia, W. B. Saunders Co., 1966, p. 95. 2. Hollander, W.: The Evaluation of Antihypertensive Therapy of Essential Hypertension in Ingelfinger, F. J.; Relman, A. S., and Finland, M.: Controversy in Internal Medicine, Philadelphia, W. B. Saunders Co., 1966, p. 97. 3. Nickerson, M.: Antihypertensive Agents and the Drug Therapy of Hypertension, in Goodman, L. S., and Gilman, A.: The Pharmacological Basis of Therapeutics, ed. 3, New York, The Macmillan Co., 1965, p. 727. 4. Berkson, D. M.: Indust. Med. & Surg. **32**:371, 1963. 5. Cohen, B. M.: M. Times **91**:645, 1963. 6. Lee, R. E., et al.: Am. J. Cardiol. **11**:738, 1963. 7. Moyer, J. H.: Am. J. Cardiol. **9**:821, 1962. 8. Moser, M.: New York J. Med. **62**:1177, 1962. 9. Wood, J. E., and Battey, L. L.: Am. J. Cardiol. **9**:675, 1962. 10. Moyer, J. H., and Heider, C.: Am. J. Cardiol. **9**:920, 1962. 11. Moser, M., and Macaulay, A. I.: New York State J. Med. **60**:2679, 1960. 12. Judson, W. E.: Nebraska M. J. 44:305, 1959. 13. Hodge, J. V.; McQueen, E. G., and Smirk, H.: Brit. M. J. **1**:5218, 1961. 14. Moyer, J. H., and Brest, A. N.: Hypertension Recent Advances, Philadelphia, Lea & Febiger, 1961, p. 633. 15. Berry, R. L., and Bray, H. P.: J. Am. Geriatrics Soc. **10**:516, 1962. 16. Reid, W. J.: J. Am. Geriatrics Soc. **13**:365, 1965. 17. Feldman, L. H.: North Carolina M. J. **23**:248, 1962.

**Contraindications:** Severe renal impairment or previous hypersensitivity. **Warning:** Ulcerative small bowel lesions have occurred with potassium-containing thiazide preparations or with enteric-coated potassium salts supplementally. Stop medication if abdominal pain, distension, nausea, vomiting or G.I. bleeding occur.

**Precautions and Side Effects:** The dose of ganglionic blocking agents, veratrum or hydralazine when used concomitantly must be reduced by at least 50% to avoid orthostatic hypotension. Caution is indicated in patients with depression, suicidal tendencies, peptic ulcer; electrolyte disturbances are possible in cirrhotic or digitalized patients. Marked hypotension during surgery is possible; consider discontinuing two weeks prior to elective surgery and observe patients closely during emergency surgery. Rauwolfia preparations may cause reversible extrapyramidal symptoms and emotional depression, diarrhea, weight gain, edema, drowsiness may occur. Bendroflumethiazide may cause increases in serum uric acid, unmask diabetes, increase glycemia and glycosuria in diabetic patients, and may cause hypochloremic alkalosis, hypokalemia; cramps, pruritus, paresthesias, rashes may occur.

**Dosage and Supply:** Initial dosage, 1 to 4 tablets daily, preferably at mealtime. Maintenance, 1 or 2 tablets daily. Rautrax-N is supplied as capsule-shaped tablets containing 50 mg. Rauwolfia serpentina whole root (Raudixin®), 4 mg. bendroflumethiazide (Naturetin®), 400 mg. potassium chloride.

**Also available:** Rautrax-N Modified — capsule-shaped tablets containing 50 mg. Rauwolfia serpentina whole root (Raudixin), 2 mg. bendroflumethiazide (Naturetin), 400 mg. potassium chloride. Both potencies available in bottles of 100. For full information, see Product Brief.

## RAUTRAX®-N

Squibb Rauwolfia Serpentina Whole Root (50 mg.) with Bendroflumethiazide (4 mg.) and Potassium Chloride (400 mg.)

SQUIBB 'The Priceless Ingredient' of every product is the honor and integrity of its maker.




The Royal Lahaina Hotel

KAANAPALI BEACH, MAUI

Your own private paradise . . . one of the loveliest resorts in the world. Wonderfully spacious cottages, each with its own lanai, overlook the green velvet fairways of the championship golf course and the white sandy beaches of the blue Pacific. A golfer's dream . . . a dreamer's holiday. Emphasis is on informality and superb dining.

Come to Maui soon. Come to the Royal Lahaina, your own private paradise by the sea.

ISLAND HOLIDAYS 2171 KALAKAUA AVE., HONOLULU
TELEPHONE: 931-111

## *Book Reviews* *continued from 160*

tests the clinician relies upon when dealing with bleeding problems. It was published prior to the knowledge of fibrin stabilizing factor.

In this era of medical practice in which there is a growing disenchantment with anticoagulant therapy in the treatment of cardiac and cerebrovascular diseases, the author attempts to present an unbiased, but experienced, presentation without becoming too involved in this controversy. In summary, the text is a very excellent survey of current anticoagulant information.

FRANCIS M. IKEZAKI, M.D.

### ★Cardiac Evaluation in Normal Infants

*By Robert F. Ziegler, M.D., 170 pp., $12.75, The C. V. Mosby Company, 1965.*

CARDIAC EVALUATION in infancy is the most difficult part of pediatric cardiology. The problem often comes down to differentiating between the normal and abnormal, which may be more difficult than it sounds, since in infancy, more than at any other time of life, the "normal" is a bell-shaped curve.

This excellent book not only points out the pitfalls associated with relying on electrocardiography, roentgenography, and auscultation but also has positive suggestions for a logical approach to the problem of cardiovascular disease in this age group.

FRANCES F. NAKAMURA, M.D.

## Also Received

### ★Oral Antidiabetic Therapy 1956-1965 with Particular Reference to Tolbutamide

*By H. A. Tucker, M.D., 676 pp., $13.50, Charles C. Thomas, 1965.*

A COMPREHENSIVE COVERAGE of significant publications in oral antidiabetic therapy with an excellent summary in the last chapter which is a must for those prescribing this form of treatment.

### The Drug, The Nurse, The Patient (Including Current Drug Handbook 1966-68), 3d Ed.

*By Mary W. Falconer, R.N., M.A., Mabelclaire Ralston Norman, R.N., B.S., M.S., H. Robert Patterson, B.S., M.S., Pharm. D., and Edward A. Gustafson, B.S., Pharm. D., 716 pp., $8.25, W. B. Saunders Company, 1966.*

PHARMACOLOGY TEXT for nurses.

### Ciba Foundation Symposium on Preimplantation Stages of Pregnancy

*Edited by G. E. W. Wolstenholme, O.B.E., M.A., F.R.C.P., F.I. Biol., 430 pp., $13.50, Little, Brown and Company, 1965.*

A COMPREHENSIVE SYMPOSIUM on basic research in the various aspects of fertilization.

*continued page 166*

WILLIAMS MORTUARY

"CHAPEL OF THE CHIMES"

1076 S. Beretania St., Phone 52-587 Ample Parking Adjoining Mortuary

OVER A CENTURY OF SERVICE

*"Service measured not by gold but by the Golden Rule"*

***MEMBER***

National Selected Morticians, National Funeral Directors Association, Order of the Golden Rule, Hawaii Funeral Directors Association



*Adaptation from Shakespeare Rare Print Collection*

*"Give me a bowl of wine*
*—in this I bury*
*all unkindness"*

—SHAKESPEARE



**DEAR DOCTOR:**

Will Shakespeare was a pretty fair hostler and real estate investor, a pal of Francis Drake and Walter Raleigh, much admired by Queen Elizabeth, and a tophole poet and playwright —but no physician.

Nevertheless, he had a rather good idea of the helpfulness of wine in cases of stress, as you can see above.

Like Will, we wish to recommend a daily bit of wine, with your meals for your own personal stress, Doctor, in your rugged profession.

Also, for your wife's stress at home, we'd like to prescribe a 24-page folder, "WINE COOKERY THE EASY WAY," which will help her to relax in the kitchen (and help you at the barbecue). We'll mail it to you (free) if you'll just drop us a note on your professional letterhead.

By the way, we'll also send you our newly revised 64-page booklet, "USES OF WINE IN MEDICAL PRACTICE," which summarizes a quarter century of scientific research, in America and Europe, as an aid to your profession.

We hope you will request one or both of these free booklets.

As you know, wine stimulates gastric flow; can help the convalescing patient; the patient lacking appetite; can help relieve anxiety; can help patients suffering from the malabsorption syndrome—and helps hospital and geriatric home morale. Shakespeare had a good idea there. And many physicians and hospital administrators are also sharing that idea.

Here's a toast in California wine, Doctor—to your health!

*The Winemakers of California*

WINE ADVISORY BOARD, 717 MARKET ST., DEPT 1, SAN FRANCISCO, CALIF. 94103

# new

**"Doctor, when the kids act up and nothing goes right, I get these throbbing pains in the back of my head."**

## a new formulation that relieves pain in tension headache and neuralgia

Dialog is a combination of 15 mg allobarbital and 300 mg acetaminophen. Allobarbital, a proven barbiturate, provides desirable sedation in patients experiencing pain and discomfort. Acetaminophen is a nonsalicylate analgesic-antipyretic, well tolerated and useful in a wide range of mildly painful and febrile conditions.

Dialog is well tolerated, even by those sensitive to aspirin. It is nonirritating to the gastrointestinal tract and, in recommended dosage, has no adverse effects on the kidneys.

- Raises the pain threshold
- Suppresses the pain-producing mechanism
- Reduces emotional tension

2/3453 MK-3




# Dialog™

## (allobarbital and acetaminophen CIBA)

**Indications:** For relief of pain and discomfort of simple headache; neuralgia, myalgia, and musculoskeletal pain; dysmenorrhea; bursitis; sinusitis; fibrositis. Also indicated to reduce fever and to relieve discomfort due to respiratory infections, influenza, and other febrile conditions.

**Contraindication:** Not recommended during pregnancy.

**Caution:** May be habit-forming. Do not use in patients sensitive to barbiturates or in those with moderate to severe hepatic disease.

**Side Effects:** Nausea, transitory dizziness, rash. Overdosage of allobarbital produces symptoms typical of acute barbiturate excess.

**Dosage:** *Adults:* 1 or 2 tablets every 4 hours. Not to exceed 8 tablets in 24 hours. *Children 6 to 12:* ½ to 1 tablet every 4 hours. Not to exceed 4 tablets in 24 hours.

**Supplied:** *Tablets* (white, scored), each containing 15 mg allobarbital and 300 mg acetaminophen; units of 3 bottles of 30.

**For your convenience — prescription-size bottle of 30.**

CIBA Pharmaceutical Company, Summit, N.J.

CIBA

WHEN YOU HAVE
A CALL TO MAKE
...CALL HAWAIIAN AIRLINES
FOR CONVENIENT JET FLIGHTS
TO ALL ISLANDS
WHETHER FOR
BUSINESS OR PLEASURE

FOR RESERVATIONS CALL:

| HONOLULU | KAHULUI | LANAI |
|---|---|---|
| 817-611 | 75-011 | 3-222 |
| HANA | KAMUELA | LIHUE |
| 442-483 | 858-505 | 2-751 |
| HILO | KONA | MOLOKAI |
| 50-811 | 256-465 | 37-475 |

HAWAIIAN AIRLINES
Holder of the World's Safety Record

*Book Reviews* continued from 162

### Ciba Foundation Symposium on Transcultural Psychiatry

*Edited by A. V. S. De Reuck, M.Sc., D.I.C., A.R.C.S., and Ruth Porter, M.R.C.P., 396 pp., $12.00, Little, Brown and Company, 1965.*

THE INFLUENCE of the national character on psychiatric symptoms, care, and diagnosis are comprehensively discussed in this symposium.

### Medical Pharmacology: Principles and Concepts, 3d Ed.

*By Andres Goth, M.D., pp. 668, The C. V. Mosby Company, 1966, $12.50.*

A CONCISE PHARMACOLOGY TEXT that may serve as a ready source of information for the busy practitioner.

### The Cell: An Atlas of Fine Structure

*By Don W. Fawcett, M.D., 448 pp., $11.00, W. B. Saunders Company, 1966.*

AN EXTREMELY well-illustrated text on electron microscopy.

### Modern Treatment, January 1966

*Treatment of hypertension—Guest edited by Alvin P. Shapiro, M.D. Treatment of pituitary disorders—Guest editor Raymond V. Randall, M.D. Hoeber Medical Division, Harper & Row, Publishers. Sold by subscription only, 6 copies per year (bi-monthly), $16.00 per year.*

A GOOD REVIEW of some of the current thoughts on treatment of hypertension. The treatment of pituitary disorders is also well covered. ■




Your stationery
is a reflection
of you...
be certain
the reflection is good!

*star-bulletin printing company*

*the hallmark of fine printing in honolulu*

# "'Tranquilizer' is not a good word"[1]

THIS classification is psychologically too seductive, pharmacologically too unspecific, and in terms of results not infrequently untrue."[2]

What is a tranquilizer? According to the 24th Edition of Dorland's Medical Dictionary[3] a tranquilizer is "an agent which acts on the emotional state, quieting or calming the patient without affecting clarity of consciousness."

Defining a drug by its effects, however, can be misleading. The same effects by which the dictionary defines a tranquilizer have sometimes been seen after administration of a sedative — or, for that matter, a placebo.

Ambiguous though the term may be, it appears to be here to stay. The 1966 edition of the Physicians' Desk Reference[4] lists 42 tranquilizers indicated for treatment of anxiety and apprehensive states.

### 'Tranquilizers' have differences in action, differences in effect

Although all tranquilizers are intended to calm anxious patients there *are* differences in their actions — and in their effects. They have been divided into three categories — the rauwolfia group, the 'minor' tranquilizers, and the phenothiazines.[5]

Although the tranquilizing effect of rauwolfia has been known for centuries, its use as an antipsychotic agent in current practice has diminished.[5]

A 'minor' tranquilizer is often prescribed to achieve more than one effect. Thus, besides being tranquilizers some of these compounds may be muscle relaxants, antihistaminics with some calming action, anticholinergic sedatives, or antispasmodics.[5]

The phenothiazines are considered 'major' tranquilizers because they alter psychotic behavior.[1] This classification may have done them more harm than good because it implies that the phenothiazines should be reserved for the more severely disturbed. This is not necessarily true.

### The phenothiazines — and the problem of sedation

One of the problems of prescribing phenothiazines for ambulatory patients has been the fear that excessive sedation will impair the patient's ability to function. This, however, is less of a problem with some of the phenothiazines.

"Clinically they may be differentiated primarily in terms of their potency and the extent of their sedative effect, which appear to be inversely proportional. That is, the least potent, the one which is used in highest dosage, chlorpromazine, is the most sedative, while the reverse holds true for fluphenazine."[6]

In a recent report on various studies conducted over several years evaluating 360 patients treated for anxiety and stress with seven phenothiazines, this inverse relationship of potency to sedation was confirmed.[7] Also under consideration was the degree to which the particular phenothiazines neutralized anxiety (the angolytic index). Interestingly enough there was, again, an inverse relationship. The most sedative of the phenothiazines appeared to be the least active in neutralizing anxiety. Fluphenazine, one of the least sedative, on the other hand, was found to be most effective in relieving anxiety.[7]

**RELATIVE SEDATIVE AND ANGOLYTIC INDICES OF PRINCIPAL PHENOTHIAZINES***

| DRUG | SEDATIVE INDEX | ANGOLYTIC INDEX | BASED ON STANDARD DOSE OF |
|---|---|---|---|
| Chlorpromazine | 100 | 15 | 25 mgs. |
| Triflupromazine | 100 | 15 | 25 mgs. |
| Thioridazine | 90 | 17 | 25 mgs. |
| Perphenazine | 15 | 25 | 4 mgs. |
| Carphenazine | 25 | 25 | 25 mgs |
| Trifluoperazine | 3.3 | 95 | 2.0 mgs. |
| Fluphenazine | 3.5 | 100 | 2.5 mgs. |

*adapted from Sainz[7]

### Prolixin is therapeutically effective without excessive sedation

When used as a 'tranquilizer' in general medical practice, in many patients Prolixin (Squibb Fluphenazine Hydrochloride) suppresses anxiety, but not normal activity. These two features are of particular importance to patients who must be able to live and work without their normal daily activities being restricted.

Because of its longer duration of action, Prolixin, in doses of as little as one to three milligrams in adults, generally taken once a day, is effective in maintaining many patients free of their symptoms of anxiety and tension.

**Contraindications:** Do not use with high doses of hypnotics or in patients with subcortical brain damage. Use with caution in patients with a history of convulsive disorders. Severe reactions may occur in patients with idiosyncrasy to other centrally-acting drugs, and severe hypotension may occur in patients with special medical disorders, e.g. mitral insufficiency and pheochromocytoma.

**Precautions:** Effects of atropine, anesthetics and C.N.S. depressants may be potentiated. Hypotension may occur in patients undergoing surgery. Do not use epinephrine for treatment of the hypotensive reactions which may appear in patients on phenothiazine therapy.

**Side Effects:** Extrapyramidal reactions, allergic skin reactions, the possibility of anaphylaxis, drowsiness, visual blurring, dizziness, insomnia, nausea, anorexia, salivation, edema, perspiration, dry mouth, abnormal lactation, polyuria, hypotension, and jaundice and biliary stasis may occur. Routine blood counts are recommended to determine possible blood dyscrasias; if symptoms of upper respiratory infection occur, discontinue drug and institute appropriate therapy.

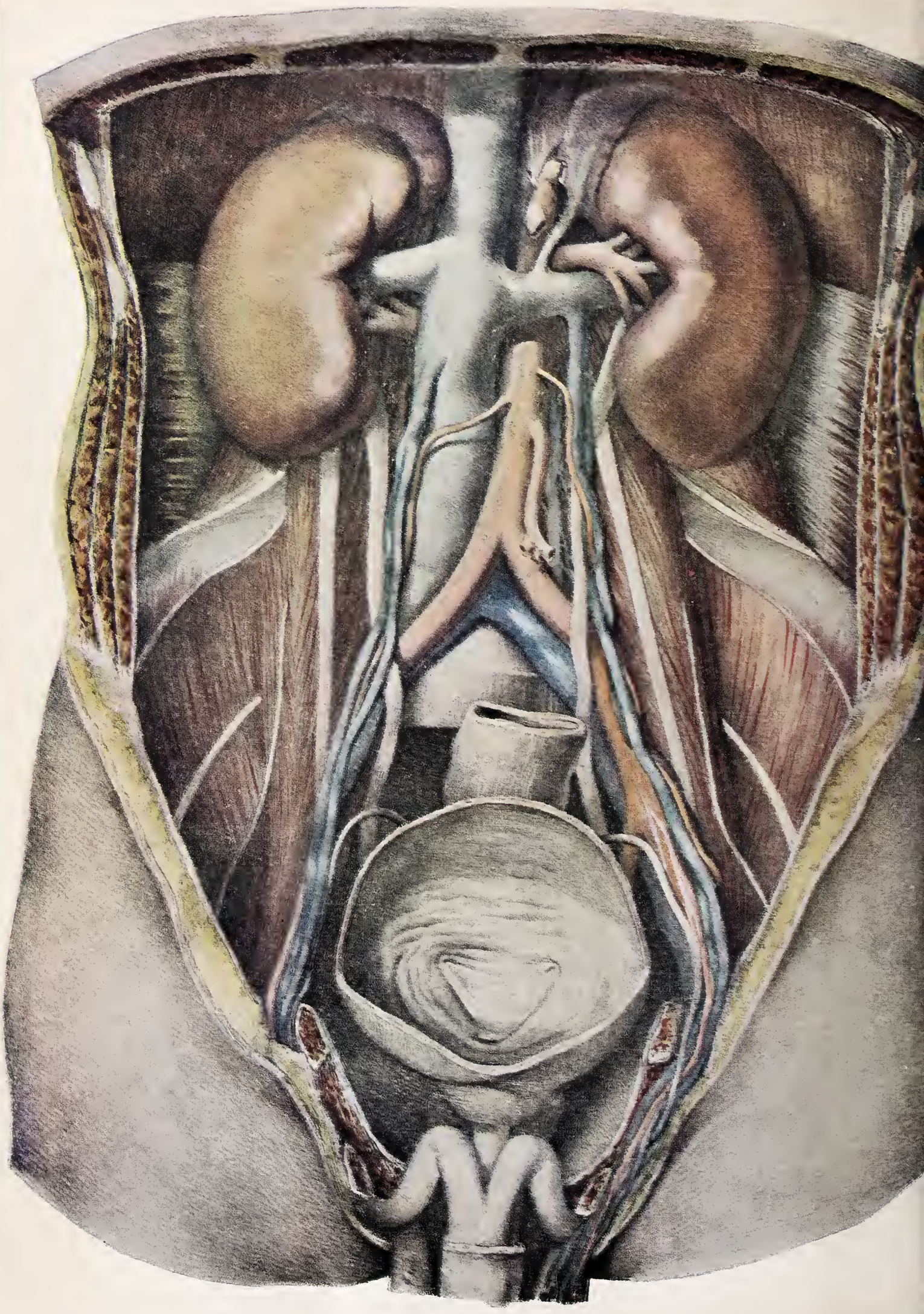
**Available:** 1 mg. tablets. Bottles of 50 and 500.

For full prescribing information, see package insert

**References:** 1. Simpson, G.M.: Postgrad. Med. 39:557, 1966. 2. Freyhan, F.A.: Am. J. Psychiat. 115:577, 1959. 3. Dorland's Illustrated Medical Dictionary, ed. 24, Philadelphia, W. B. Saunders Co., 1965, p. 1603. 4. Physicians' Desk Reference, 1966, Oradell, N.J., 1965, p. 310. 5. Cohen, S.: Northwest Med.: 65:197, 1966. 6. Detre, T., and Jarecki, H.: Connecticut Med. 25:553, 1961. 7. Sainz, A.: Psychosomatics 5:167, 1964.

PROLIXIN®
SQUIBB FLUPHENAZINE HYDROCHLORIDE

SQUIBB 'The Priceless Ingredient' of every product is the honor and integrity of its maker.



# Wide-range bactericidal action for genitourinary infections

# NEW OMNIPEN® (AMPICILLIN) WYETH

A penicillin that exhibits effectiveness within the gram-positive spectrum of penicillin G* and the gram-negative spectrum of chloramphenicol and the tetracyclines.*

Active at foci of infections—kidney, ureter, bladder or urethra.

Effective against many gram-negative and gram-positive pathogens—thus may be valuable not only in genitourinary but also in common respiratory and gastrointestinal infections.

Normally produces high and persistent levels in blood and high concentrations in bile and urine.

Significant inherent stability.

**Exclusive of penicillinase-producing bacteria.*

**Indications:** Urinary tract infections, especially those caused by *E. coli*, *Proteus mirabilis*, and *Streptococcus faecalis* and *viridans;* respiratory infections caused by *H. influenzae*, pneumococci, streptococci, and nonpenicillinase-producing staphylococci; and gastrointestinal infections caused by *Shigella* and *Salmonella*, including *Sal. typhosa*.



**Contraindications:** Hypersensitivity to penicillin; infections due to penicillinase-producing staphylococci and other penicillinase-producing bacteria.

**Precautions:** If allergic reaction occurs, discontinue ampicillin and administer epinephrine, corticosteroids, antihistamines and/or pressor amines as indicated. Transient moderate elevation of SGOT values of undetermined significance was noted in a few infants. Liver and kidney function as well as hematopoietic tests are advisable during therapy, particularly in infants. As with other antibiotics, precautions should be taken against gastrointestinal superinfection. Safety for use in pregnancy has not been established.

**Adverse Reactions:** Occasional mild side effects as urticaria, skin rash, pruritus, diarrhea, nausea and vomiting. There have been no reports of blood dyscrasias, liver or kidney damage. Anaphylaxis has been reported.

**Composition:** Capsules, 250 mg.

**American Hospital Formulary Service Category No. 8:12.16.**

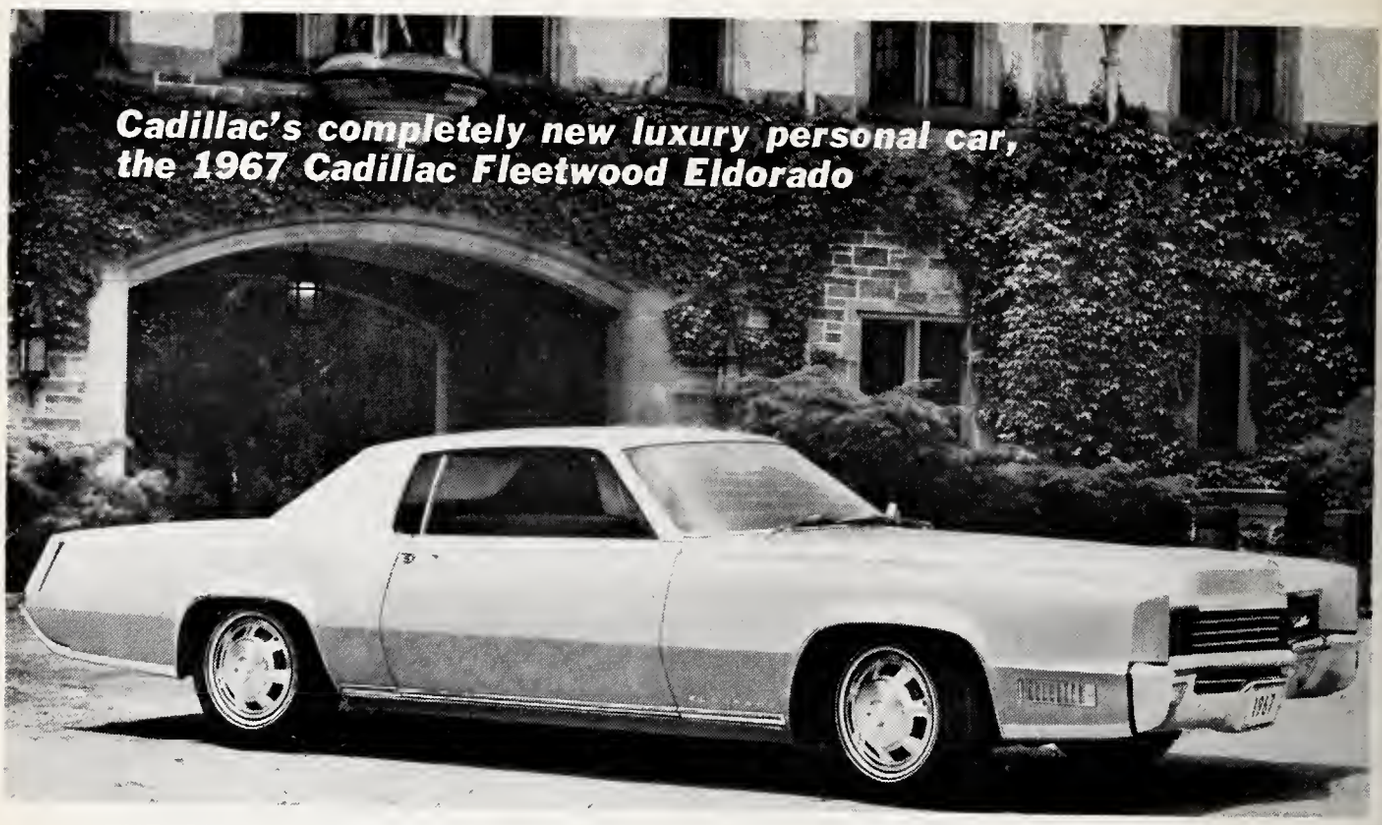
**Wyeth Laboratories Philadelphia, Pa.**

Wyeth® SERVICE TO MEDICINE

# Our "Angels"


| | Page |
|---|---|
| American Tobacco Co. | 93 |
| Ames Company, Ltd. | 171 |
| Amfac, Inc. | 83 |
| Ayerst Laboratories | 172 |
| Bentley Sales | 160 |
| Bishop Trust Co. | 96 |
| Bristol Laboratories | 88, 89, 150, 151 |
| Burroughs Wellcome & Co. (U.S.A.) Inc. | 101 |
| Carnation Co. | 92 |
| Cen-Pac Properties, Inc. | 159 |
| Ciba Pharmaceutical Co. | 164, 165 |
| Coca-Cola Bottling Co. of Honolulu | 166 |
| Geigy Pharmaceuticals | 84, 85, 153 |
| General Diagnostics | 139 |
| Hawaii Medical Service Associaiton | 155 |
| Hawaiian Airlines | 166 |
| Hoeschst Pharmaceuticals, Inc. | 97, 98, 99, 100 |
| Island Holidays | 162 |
| Kahanaola | 102 |
| Lederle Laboratories, Inc. | 81 |
| Lilly, Eli, & Co. | 77, 104 |
| Mead Johnson Laboratories | 156, 157 |
| Medical Placement Bureau | 160 |
| Merrell, Wm. S., Co. | 86, 87 |
| O'Leary, Lydia, of Hawaii | 158 |
| Optical Dispensers of Hawaii, Inc. | 160 |
| Parke, Davis & Co. | 78 |
| Pitman-Moore Company | 90, 91 |
| Robins, A. H. Co., Inc. | Insert (between 100 & 101) Insert (between 148 & 149), 149 |
| Roche Laboratories | 103 |
| Schuman Carriage Co., Ltd. | 170 |
| Searle, G. D., & Co. | 94, 95 |
| Squibb, E. R., & Sons | 79, 161, 167 |
| Star-Bulletin Printing Co. | 166 |
| Syntex Laboratories | 143, 144, 145, 146, 147 |
| Williams Mortuary | 162 |
| Wine Advisory Board | 163 |
| Wyeth Laboratories | 168, 169 |






THE ONLY QUESTION THIS YEAR IS: WHICH CADILLAC?

*See all the exciting new Cadillac models at* **SCHUMAN'S**

*1234 South Beretania Street*

January–February, 1967

# HAWAII MEDICAL JOURNAL




CAL CENTER LIBRARY
EB 21 1967
an Francisco 22,

*In this issue*

**Hawaii State Hospital**
**–What it does!**

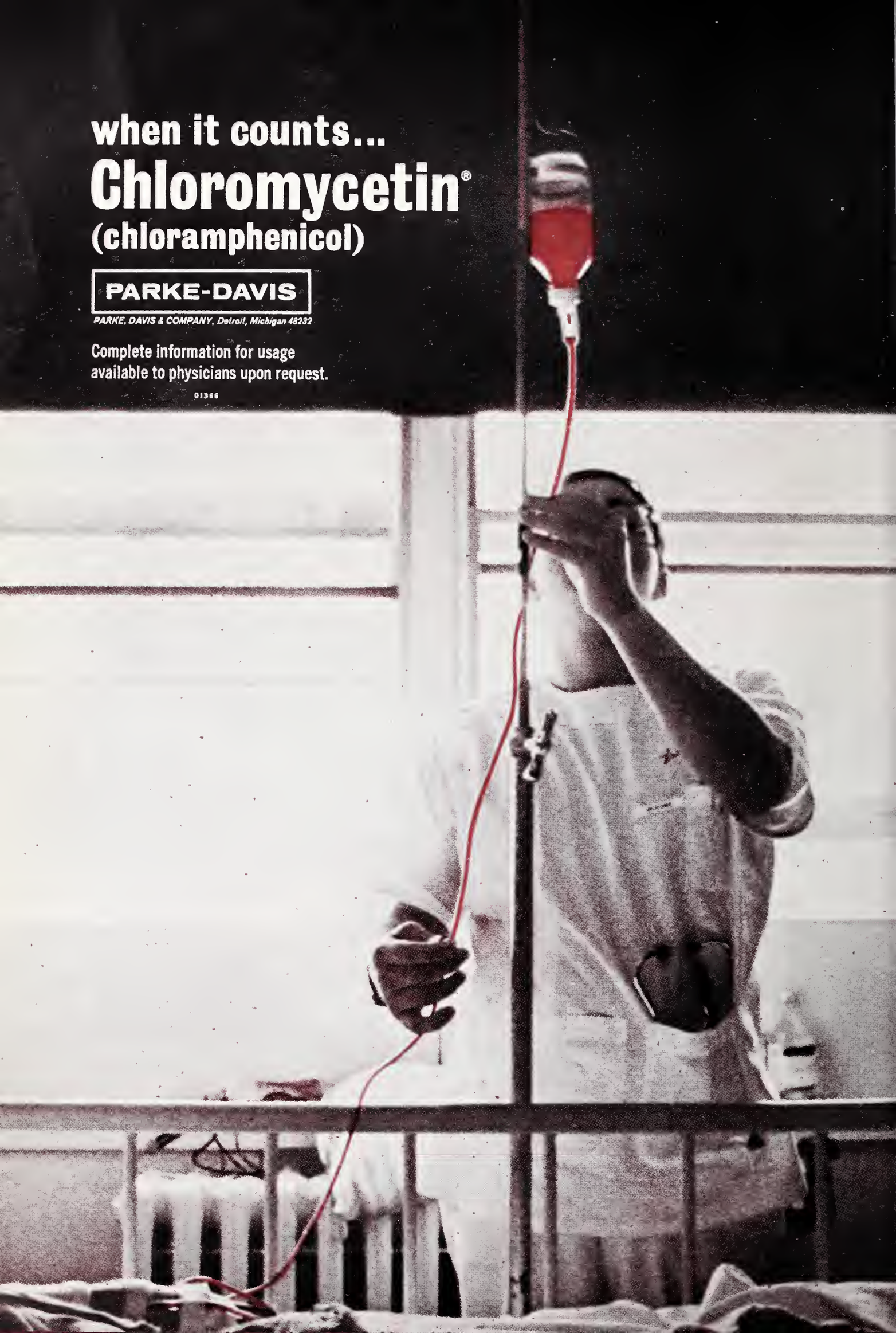
**Who eats what?**

**Cancer Society report**

Something special
Darvon® Compound-65
Each Pulvule® contains 65 mg. propoxyphene hydrochloride, 227 mg. aspirin, 162 mg. phenacetin, and 32.4 mg. caffeine.
Lilly HO6
Lilly HO6
CODE™
ntification code, Lilly)
quick, positive
identification.
Additional information available to the medical profession upon request.
Eli Lilly and Company
Indianapolis, Indiana 46206
Lilly
700087

*Table of contents, page 178*

VOLUME 26 • NUMBER 3


when it counts...
Chloromycetin®
(chloramphenicol)
PARKE-DAVIS
PARKE, DAVIS & COMPANY, Detroit, Michigan 48232
Complete information for usage
available to physicians upon request.
01366

to help restore and stabilize the intestinal flora

# LACTINEX®

## TABLETS & GRANULES

for fever blisters and canker sores of herpetic origin

LACTINEX contains a standardized viable mixed culture of *Lactobacillus acidophilus* and *L. bulgaricus* with the naturally occurring metabolic products produced by these organisms.

LACTINEX was introduced to help restore the flora of the intestinal tract in infants and adults.[1,2,3,4]

LACTINEX has also been shown to be useful in the treatment of fever blisters and canker sores of herpetic origin.[5,6,7,8]

No untoward side effects have been reported to date.

*Literature on indications and dosage available on request.*

**HYNSON, WESTCOTT & DUNNING, INC.**

H&WD

BALTIMORE, MARYLAND 21201

(LX03)

*References:* (1) Siver, R. H.: CMD, *21*:109, September 1954. (2) Frykman, H. H.: Minn. Med., *38*:19-27, January 1955. (3) McGivney, J.: Tex. State Jour. Med., *51*:16-18, January 1955. (4) Quehl, T. M.: Jour. of Florida Acad. Gen. Prac., *15*:15-16, October 1965. (5) Weekes, D. J.: N.Y. State Jour. Med., *58*:2672-2673, August 1958. (6) Weekes, D. J.: EENT Digest, *25*:47-59, December 1963. (7) Abbott, P. L.: Jour. Oral Surg., Anes., & Hosp. Dental Serv., 310-312, July 1961. (8) Rapoport, L. and Levine, W. I.: Oral Surg., Oral Med. & Oral Path., *20*:591-593, November 1965.

LX

HAWAII MEDICAL JOURNAL

*Published Bi-Monthly by the* HAWAII MEDICAL ASSOCIATION (Incorporated in 1856 under the Monarchy), 510 S. Beretania St., Honolulu, Hawaii 96813 • *Editor,* HARRY L. ARNOLD, JR., M.D. • *News Editor,* HENRY N. YOKOYAMA, M.D. • *Managing Editor,* LEE MCCASLIN

VOLUME 26, NUMBER 3 • JANUARY-FEBRUARY, 1967 • $6.00 A YEAR, $1.00 A COPY

The JOURNAL may not be held responsible for opinions expressed in papers, discussions, communications, or advertisements. The advertising policy of the HAWAII MEDICAL JOURNAL is governed by the rules of the Council on Drugs of the American Medical Association. The right is reserved to reject material submitted for editorial or advertising columns. All material for publication must be in the hands of the editor on or before the 10th day of the month preceding publication date. Reprints of original articles will be supplied at actual cost, provided request is attached to manuscript or made in sufficient time before publication. A reasonable number of cuts and illustrations accompanying an article will be accepted for printing. The right is reserved to ask the author to bear cost of these when it is found necessary to do so.

Copyright, 1967, by the Hawaii Medical Association, Honolulu, Hawaii. Entered as second class matter, October 17, 1941, at the Post Office in Honolulu, Hawaii, under the Act of August 24, 1912. Office of Publication: Mabel L. Smyth Memorial Building, 510 S. Beretania St., Honolulu, Hawaii 96813.

# The Hawaii Medical Association

## Officers 1966-1967

President • THEODORE T. TOMITA, *Honolulu*
President-Elect • B. A. RICHARDSON, *Honolulu*
Past President • O. D. PINKERTON, *Honolulu*
Secretary • R. VARIAN SLOAN, *Honolulu*
Treasurer • HERBERT Y. H. CHINN, *Honolulu*

County Presidents

Hawaii County • ED B. HELMS, *Hilo*
Honolulu County • JOHN J. LOWREY, *Honolulu*
Kauai County • Y. MIYASHIRO, *Waimea*
Maui County • KENNETH HALING, *Kahului*

Delegate to A.M.A. • RICHARD D. MOORE, *Honolulu*
Alt. Delegate to A.M.A. • GEORGE H. MILLS, *Honolulu*

## Councillors 1966-1967

Maui • JOSEPH E. ANDREWS
Honolulu • GROVER H. BATTEN
Honolulu • BERNARD W. D. FONG
Honolulu • ANDREW C. IVY, JR.
Hawaii • ROBERT M. MIYAMOTO
Kauai • SAMUEL R. WALLIS

## Officers—County Societies—1967

### HAWAII

ETTA WRIGHT BEST • President
FRANCIS F. C. WONG • Vice President
REGINALD S. CARVALHO • Secretary
JAMES K. MATAYOSHI • Treasurer

### HONOLULU

• GEORGE H. MILLS
• KEITH F. O. KUHLMAN
• HERBERT Y. H. CHINN
• K. S. TOM

### KAUAI

BURT O. WADE • President
SAMUEL WALLIS • Vice President
JAMES P. WARNER • {Secretary / Treasurer}

### MAUI

• BILLIE FERN STROTHER
• SAKAE UEHARA
• JOHN F. MORRIS

# Blood-glucose creening for all our patients?



ecause "Abnormalities of glucose tabolism are among the [most mmon] encountered in clinical actice...."* Simple, quick, econom- l blood-glucose screening h DEXTROSTIX® Reagent Strips is acticable in every regular physical amination, emergency situation, d whenever hypo- or hyper- cemia may be of clinical gnificance—for "The precision d accuracy of DEXTROSTIX meet the need for an always ailable simple screening thod...."* All that is required screening with XTROSTIX is 60 seconds d a globular drop of pillary or venous blood. normal readings will be valuable aid to diagnosis; rmals will help you tablish an important seline for future reference.

*arks, V., and Dawson, A.: it. M. J. *1*:293, 1965.

## DEXTROSTIX—

ovides a clinically useful etermination when performed ccording to directions†

†EXTROSTIX is not intended to replace e more precise analytical laboratory methods.

# Yes—all your patients

AMES COMPANY, INC.
Elkhart, Indiana

AMES

09165

HAWAII MEDICAL JOURNAL

# Contents

Volume 26, No. 3 • January-February, 1967

**Articles**

*Ten-Year Profile of Hawaii State Hospital: A Statistical Analysis* 201
Howard E. Gudeman, Ph.D.

*First Admissions to Hawaii State Hospital* 207
John M. Rosenfeld, Ph.D.

*Food Choice and Acculturation Among Some Ethnic Groups* 209
Kajorn Lekhakul Howard, M.S.

*Special Report: American Cancer Society, 1966 Scientific Session* 213
Norman R. Sloan, M.D.

**Editorials**

Aloha Oiaio, *Leo Bernstein!* 219

*The Autumn of Our Sorrowful Discontent* 219

**Features**

*Book Reviews* 228

*County Society Reports* 227

*Hawaii Academy of General Practice* 223

*In Memoriam—Doctors of Hawaii—LXV* 222

*New Members* 226

*Notes and News* 224

*President's Page* 218

*This is What's New!* 221

**Hawaii Technologists' Bulletin**

*Automation and the Technologist—Where Are We Going?* 232

*Automation—Threat or Promise?* 232

*New at U.H.* 233

**thdraws excess moisture. Reduces edema and inflammation.** Relieves pain of earache. "Moisture-ngry" **AURALGAN® Otic Solution** Contains the driest glycerin available for otic use, glycerin dehydrated, .4%. Does not distort the otoscopic picture. Does not blanch the tympanic membrane. Logical adjunct systemic antibacterial therapy. **Supplied:** 15 cc. bottle with separate dropper—screw cap attachment.

AYERST LABORATORIES New York, N.Y. 10017 • Montreal, Canada

# Liquid sponge!
# Dries earache away!




6715



# Preludin®
## phenmetrazine hydrochloride





# helps keep calories at arm's length

In one double-blind program* involving diet, close doctor/patient cooperation, exercise, posture instruction, and follow-up visits, 93 obese patients received Preludin or placebo. The drug and placebo were alternated every four weeks. This procedure lasted from 8 to 35 weeks.

Sixty-one percent of the patients lost more weight on Preludin than on placebo. In fact, they lost an average 1.9 pounds per week—almost four times as much as when they were on placebo!

For a decade Preludin has demonstrated similar results. Its effectiveness has been described in more than 300 published clinical reports involving more than 10,000 patients.

Preludin curbs appetite without excessive stimulation. It will work in your weight-control programs too.

*Barnes, R. H.: J.A.M.A. 166:898, 1958.

Preludin® tablets of 25 mg.
Endurets® prolonged-action tablets of 75 mg.
*Dosage:* One 25 mg. tablet two or three times daily, or one 75 mg. Endurets tablet once daily.
*Contraindications:* Severe coronary artery disease, hyperthyroidism, severe hypertension, nervous instability, and agitated prepsychotic states. Do not use with other CNS stimulants, including MAO inhibitors.
*Warning:* Do not use during the first trimester of pregnancy unless potential benefits outweigh possible risks.
*Precautions:* Use with caution in *moderate* hypertension and cardiac decompensation. Excessive use may result in a psychotic illness manifested by restlessness, mood or behavior changes, hallucinations, or delusions.
*Side Effects:* Dryness or unpleasant taste in the mouth, urticaria, and (rarely) overstimulation, insomnia, dizziness, nausea, or headache.

For details, see full Prescribing Information. 6544-III (B)

Under license from Boehringer Ingelheim G.m.b.H.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation, Ardsley, N.Y.



*Now, now, Mrs. Forsythe, we've never lost a cold patient yet.*

When she's experiencing acute discomfort from cold symptoms, it's small wonder the patient becomes distressed about her condition.

She will breathe easier when you prescribe Novahistine LP.

Novahistine LP is a long-acting decongestant that helps restore normal mucus secretion and ciliary activity—physiologic mechanisms which prevent infection of the respiratory tract. A dose of two tablets taken in the morning and repeated in the evening will usually keep air passages clear for 24 hours.

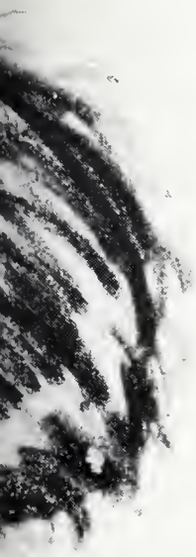
Use cautiously in individuals with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution patients who operate machinery or motor vehicles that drowsiness may result.

Each Novahistine LP tablet contains: phenylephrine hydrochloride, 25 mg., and chlorpheniramine maleate, 4 mg.

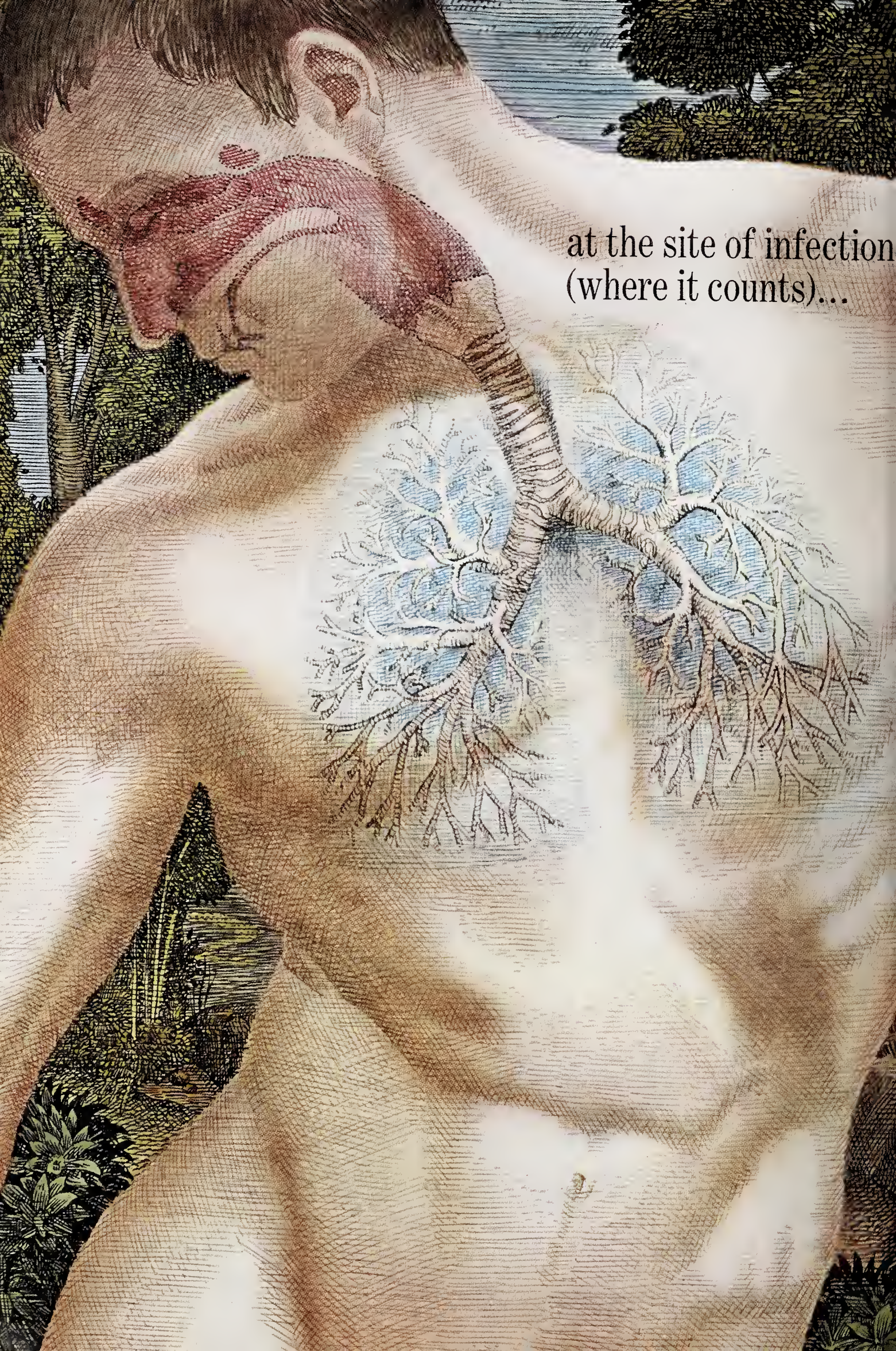
DOW **PITMAN-MOORE** Division of The Dow Chemical Company, Indianapolis

**NOVAHISTINE® LP**

*For relief of nasal congestion.*



Saxon


at the site of infection
(where it counts)...

# Ilosone® provides more antibacterial activity than any other oral erythromycin

**Acid stable, better absorbed ... Ilosone produces faster, higher, more prolonged blood levels, even in the presence of food**[1-3]

Because it is the most active form of oral erythromycin, Ilosone can help assure consistently greater antibacterial activity at the site of infection. Ilosone produces peak antibacterial blood levels two to four times those of other erythromycin preparations.[1,2] Not only are these levels attained earlier, but they are maintained for much longer periods. Even the presence of food does not seem to affect the activity of Ilosone.[1,3]

In the treatment of patients with bacterial infections susceptible to erythromycin, Ilosone has compiled an excellent therapeutic record. Since it exerts its greatest activity against gram-positive organisms, it is particularly useful in common respiratory and soft-tissue bacterial infections. Ilosone kills—not merely inhibits—streptococci, pneumococci, and more strains of staphylococci than any other macrolide antibiotic. This bactericidal action, coupled with the high antibacterial levels attained, makes Ilosone especially valuable in patients with low host resistance, such as infants, debilitated individuals, and diabetics.

Ilosone has shown no cross-resistance with penicillin and may be effective against organisms that have become resistant to that agent. Despite its high antibacterial activity, Ilosone has demonstrated a low incidence of side reactions. Blood dyscrasias, ototoxicity, and tooth staining have not been observed. Infrequent cases of drug idiosyncrasy, manifested by a cholestatic jaundice, have occurred, but there have been no known definite residual effects.

**Ilosone®** Lilly
**Erythromycin Estolate**

*(See next page for prescribing information.)*

# Ilosone®/ the most active oral form of erythromycin

**Description:** Ilosone is the most active form of oral erythromycin that has been developed. Because it is stable in acid, well absorbed, and excreted in lesser amounts in the bile, it provides faster, higher, and longer-lasting levels of antibacterial activity (ABA) in the serum, even when taken with food, than do comparable doses of erythromycin.

**Indications:** Ilosone is indicated in infections caused by microorganisms sensitive to its action (especially staphylococci, hemolytic streptococci, and pneumococci). The drug is therefore useful in a high proportion of bacterial diseases encountered in clinical practice and particularly in the treatment of bacterial infections of the upper and lower respiratory tract and soft tissues.

In the treatment of acute bacterial pharyngitis and tonsillitis, this antibiotic has promptly eradicated the bacteria (streptococci) and has produced a parallel prompt clinical improvement. There have been no group A beta-hemolytic streptococci resistant to this preparation. In beta-hemolytic streptococcus infections, treatment should be maintained for ten days to prevent the development of rheumatic fever or glomerulonephritis.

Erythromycin estolate has proved to be very effective in pneumococcus pneumonia and in acute bronchitis with pneumococci on culture. Bronchopneumonia and otitis media in children have responded well to its use.

The antibiotic has been used very successfully in staphylococcus infections. Good therapeutic results have been obtained in soft-tissue infections, abscesses, cellulitis, carbuncles, wound infections, and furunculosis.

In serious staphylococcus infections, erythromycin preparations should be used only in combination therapy with other antimicrobial agents. As is the case with any treatment regimen used in these severe conditions, surgical procedures should be performed when indicated, and large dosages of the antimicrobial agents should be employed. In this fashion, Ilosone has been effective in staphylococcus pneumonia, osteomyelitis, septicemia, empyema, and meningitis.

Multiple 500-mg. doses of the drug have been useful in gonorrhea and syphilis. Since penicillin is the drug of choice for the treatment of syphilis and gonorrhea, erythromycin estolate should be employed for these infections only in patients with a history of penicillin allergy. Also, other infections due to susceptible bacteria in patients known to be hypersensitive to penicillin or other antibiotics may be considered for treatment with Ilosone.

**Contraindications: Ilosone is contraindicated in patients with a known history of sensitivity to this drug and in those with preexisting liver disease or dysfunction.**

**Side-Effects:** Data obtained from seven years' use of propionyl erythromycin ester and erythromycin estolate (Ilosone) indicate that hepatic dysfunction with or without clinical jaundice may occur during or following courses of therapy with the drug.

Changes in liver function tests in such cases have been indicative of intrahepatic cholestasis. The symptoms appear to be the result of a form of sensitization. The initial symptoms have appeared in some cases after a few days of treatment but generally have followed one or two weeks of continuous therapy or several courses of the drug. Symptoms reappear promptly if the drug is readministered to sensitive patients, usually within forty-eight hours. Eosinophilia was noted in peripheral blood counts. The findings readily subsided without apparent residual effects when treatment was discontinued. Recovery was delayed in one reported instance. The physician indicated in this case that either drug-induced jaundice or viral hepatitis may have been responsible for the findings.

In one clinical study involving ninety-three patients treated with the antibiotic, three cases of jaundice were observed and an additional eleven cases developed some changes in liver function tests. Three of the patients had abnormal liver function tests a second time on readministration of the drug.

Even though it is assumed that not all cases of jaundice have been reported, it seems clear that the number is small compared with the amount of drug that has been used. Reported cases have included persons in whom there had been administered other drugs known to be associated at times with hepatic side-effects and cases in which the presence of viral hepatitis or other disease may have been responsible for the findings. In some of the cases, associated gastro-intestinal symptoms simulated the colic of biliary tract disease. In other instances, clinical symptoms and results of liver function tests resembled findings in extrahepatic obstructive jaundice. It appears that the occurrence of jaundice after administration of Ilosone is infrequent, but further investigations are being made to estimate its incidence more accurately.

In those cases mentioned above in which jaundice appeared to be definitely related to use of the drug, laboratory findings w characterized by increased direct-reacting bilirubin, elev alkaline phosphatase levels, negative or weakly positive cep flocculation and thymol turbidity tests, elevated serum glut oxalacetic transaminase levels, peripheral eosinophilia, and mal cholecystograms.

Individual idiosyncrasy seems evident since jaundice has been reported in other patients taking prolonged courses of medication. Patients with chronic infection have been given to 2 Gm. of the drug daily for periods of two to six months, patients with rheumatic fever have taken prophylactic dose 0.5 Gm. daily for two years without difficulty. In one grou 144 patients who received the drug daily for two years, no ja dice was noted. It was of interest that members of six of t patients' families, who were not taking the drug, had epis of jaundice during the study period.

Transaminase and serum alkaline phosphatase levels w determined in a group of fifty-four adults and children who t 250 mg. of Ilosone daily for an average of sixteen month rheumatic fever prophylaxis. The results were compared w those of a similar group of forty-four patients who received p icillin. There were no cases of jaundice in either group. Eleva of SGPT and serum alkaline phosphatase levels during the cou of treatment was observed in one patient treated with Ilos and in two patients treated with penicillin. Seven other patie in the group receiving Ilosone and four others in the penici group showed elevations in one of the tests at some time dur administration of the drugs.

Very satisfactory therapeutic results, without toxicity, w reported in 102 pediatric patients who received short-term (t day) courses of Ilosone in the treatment of streptococcus inf tions. Results of liver function tests in these patients were co parable to those in a similar control group who had recei penicillin.

Gastro-intestinal disturbances not associated with hepatic fects are observed in a small proportion of individuals as a res of a local stimulating effect of the medication on the alimenta tract; however, the normal intestinal gram-negative bacter flora is not appreciably altered by erythromycin drugs.

Although allergic manifestations are uncommon with the u of erythromycin, there have been occasional reports of urticar skin eruptions, and, on rare occasions, anaphylaxis.

**Administration and Dosage:** Ilosone is administered orally.

Ilosone Pulvules®
Ilosone Chewable Tablets
Ilosone Drops
Ilosone, 125, for Oral Suspension

For infants and for children under twenty-five pounds of bo weight, the usual dosage is 5 mg. per pound every six hours; f children twenty-five to fifty pounds, 125 mg. every six hou (Tablets Ilosone Chewable should be chewed or crushed a swallowed with water.)

For adults and for children over fifty pounds, the usual dosa of Ilosone is 250 mg. every six hours.

For severe infections, these dosages may be doubled.

When larger doses are indicated, parenteral erythromyc therapy should be considered.

In the treatment of syphilis, the recommended total dosage 20 to 30 Gm. given in divided doses for a period of ten to fifte days. Close follow-up of the patient is necessary since erythr mycin drugs have not had adequate evaluation in all stages syphilis. Examinations of spinal fluid are recommended as pa of the follow-up therapy.

For gonorrhea, 500 mg. four times a day for four days a recommended. In the treatment of gonorrhea, patients with suspected lesion of syphilis should have a dark-field examinatio before receiving antibiotics, and monthly serologic tests shou be made for a period of three months.

**How Supplied:** Pulvules Ilosone, Capsules, N.F., 125 and 250 m (equivalent to base), in bottles of 24 and 100.

Tablets Ilosone Chewable, N.F., 125 mg. (equivalent to base in bottles of 50.

Ilosone Drops, 5 mg. (equivalent to base) per drop, in 10-cc size packages, with dropper calibrated at 25 and 50 mg.

Ilosone, 125, for Oral Suspension, N.F., 125 mg. (equivalen to base) per 5-cc. teaspoonful, in 60 and 150-cc.-size package

*References:* 1. Griffith, R. S., and Black, H. R.: Am. J. M. Sc., *247*:69, 196
2. Griffith, R. S., and Black, H. R.: Antibiotics & Chemother., *12*:398, 196
3. Hirsch, H. A., Pryles, C. V., and Finland, M.: Am. J. M. Sc., *239*:198, 1960.

*Additional information available to physicians upon request.*
*Eli Lilly and Company, Indianapolis, Indiana 46206.*

Lilly

7001

# COMMON SENSE
## VS.
# NONSENSE

*"It's unwise to pay too much, but it's worse to pay too little. When you pay too much, you lose a little money — that is all. When you pay too little, you sometimes lose everything, because the thing you bought was incapable of doing the thing it was bought to do. The common law of business balance prohibits paying a little and getting a lot — it can't be done. If you deal with the lowest bidder, it is well to add something for the risk you run, and if you do that you will have enough to pay for something better."*

*— John Ruskin (1819-1900)*

WE AT AMFAC DRUG believe in providing you with the most complete inventory possible and fast same-day delivery service. Hawaii's medical profession and the people of our state deserve complete, effective drug service.

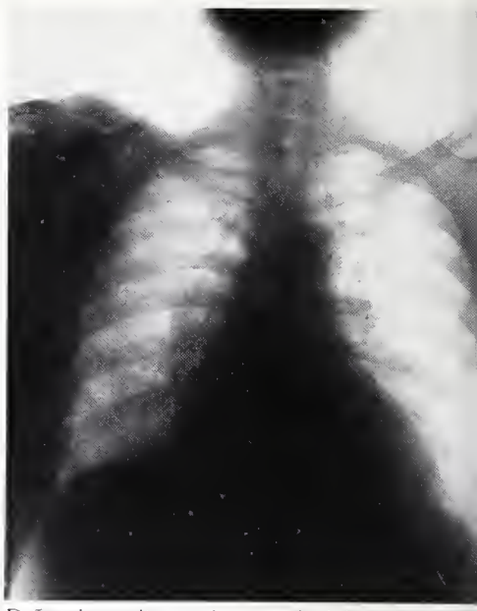
Medicine is not a cut rate field.

Charles L. Hedlund
*MANAGER*

John G. Kawafuchi
*SALES MANAGER*

**AMFAC INC DRUG DEPARTMENT**

# In chronic respiratory infections:



Diffused mottling in lower right lobe consistent
bronchopneumonia.



Direct bronchoscopy reveals a chronic inflamma
response.



Spirometer measuring pneumo-capacity, useful in e
uating degree of emphysema.

# You can minimize recurrence with this single bactericidal broad-spectrum agent.

Now, instead of tetracycline, penicillin-streptomycin or chloramphenicol, you can use a single broad-spectrum antibiotic—Polycillin (ampicillin trihydrate)—against bacterial infections in pulmonary emphysema, chronic bronchitis and pneumonia.[1-6] Bactericidal against *D. pneumoniae*, Polycillin (ampicillin trihydrate) is also more active than tetracycline or chloramphenicol against *H. influenzae* and many other Gram-negative pathogens. It is well tolerated and without direct toxicity in high or prolonged dosage.

Chronic bronchitis, where pneumococci often accompany the predominant *H. influenzae*, is thus a major indication for Polycillin (ampicillin trihydrate).[4] And when pneumococci are the sole pathogens, controlled clinical trial has shown that it can produce early defervescence more often than parenteral penicillin-streptomycin.[5] While Polycillin (ampicillin trihydrate) cannot reverse structural pathology, it does offer a new and practical way to minimize the chronicity of associated bacterial respiratory infection.

References: 1. May, J. R.: Postgrad. M. J. *40*:193, Suppl., (Dec.) 1964. 2. Millard, F.J.C.: Geriatrics *20*:854 (Oct.) 1965. 3. Lyons, H.A.: M.Times 93:1386 (Dec.) 1965. 4. Council on Drugs: JAMA *191*:1071 (Mar. 29) 1965. 5. Crofton, J.W., *et al.*: Brit. M.J. *1*:1329 (May 28) 1966. 6. Lyons, H.A.: JAMA *194*:1234 (Dec. 13) 1965.

BRISTOL

BRISTOL LABORATORIES/Division of Bristol-Myers Co. Syracuse, New York

BRISTOL THERAPEUTIC SUMMARY: For complete information consult Official Package Circular. *Indications:* Infections due to susceptible strains of Gram-negative bacteria (including Shigellae, *S. typhosa* and other Salmonellae, *E. coli*, *H. influenzae*, *P. mirabilis*, *N. gonorrhoeae* and *N. meningitidis*) and Gram-positive bacteria (including streptococci, pneumococci and nonpenicillinase-producing staphylococci). *Contraindications:* A history of serious allergic reactions to penicillin and infections due to penicillinase-producing organisms. *Precautions:* Typical penicillin-allergic reactions may occur, especially in hypersensitive patients. Mycotic or bacterial superinfection may occur. Experience in newborn and premature infants is limited and caution should be used in treatment, with frequent organ function evaluations. Safety for use in pregnancy is not established. In gonorrheal therapy, serologic tests for syphilis should be performed initially and monthly for 3 months. Assess renal, hepatic and hematopoietic function intermittently during long-term therapy. *Adverse Reactions:* Skin rash, pruritus, urticaria, nausea, vomiting, diarrhea and anaphylactic reactions. Mild transient elevations of SGOT or SGPT have been noted. *Usual Dosage:* Adults—250 or 500 mg. *q.* 6 *h.* (according to infection site and offending organisms). Children—50-100 mg./Kg./day in 3 to 4 divided doses (depending on infection site and offending organisms). Children weighing more than 20 Kg. should be given an adult dose. Beta-hemolytic streptococcal infections should be treated for at least 10 days. *Supplied:* Capsules—250 mg. in bottles of 24 and 100. 500 mg. in bottles of 16. For Oral Solution—125 mg./5 ml. in 60, 80 and 150 ml. bottles. 250 mg./5 ml. in 80 ml. bottles. Injectable—for I.M./I.V. use—vials of 250 mg. and 500 mg.

**Polycillin®**

(ampicillin trihydrate)

the penicillin you use like a broad-spectrum antibiotic



# following infection

*B and C vitamins are therapy:* STRESSCAPS B and C vitamins in therapeutic amounts...help the body mobilize defenses during convalescence...aid response to primary therapy. The patient with a severe infection, and many others undergoing physiologic stress, may benefit from STRESSCAPS capsules.




**Stresscaps®**

Stress Formula Vitamins Lederle

FOR PROFESSIONAL RECOMMENDATION ONLY

Each capsule contains:

| | |
|---|---|
| Vitamin $B_1$ (as Thiamine Mononitrate) | 10 mg |
| Vitamin $B_2$ (Riboflavin) | 10 mg |
| Vitamin $B_6$ (Pyridoxine HCl) | 2 mg |
| Vitamin $B_{12}$ Crystalline | 4 mcgm |
| Vitamin C (Ascorbic Acid) | 300 mg |
| Niacinamide | 100 mg |
| Calcium Pantothenate | 20 mg |

Recommended intake: Adults, 1 capsule daily, for the treatment of vitamin deficiencies. Supplied in decorative "reminder" jars of 30 and 100; bottles of 500.

LEDERLE LABORATORIES, A Division of American Cyanamid Company, Pearl River, New York

Lederle

626-6—3612



*She simply sits while the party goes on around her, already used to being the girl who is left out. She tries to lose weight—but her emotions won't let her. She becomes irritable and depressed when she doesn't eat, and anxious when she considers her future. So each time she gives up.*

*"What can I do?" she asks when she visits your office. "How can I ever stay on a diet and lose weight?"*

**A PARTICULAR COMBINATION OF ACTIONS**

# Ambar #2 Extentabs®

methamphetamine hydrochloride 15 mg., phenobarbital 64.8 mg. (1 gr.)
(Warning: may be habit forming).

**FOR THE NEEDS OF THE DIETING WOMAN**

A. H. Robins Co., Inc.
Richmond, Va. 23220

A·H·ROBINS

Ambar is formulated to specifically meet both the physical and emotional needs of the woman who is trying to lose weight. *Methamphetamine hydrochloride* has a powerful suppressant effect on the appetite and also provides a gentle psychic lift to improve mood and encourage activity. The *phenobarbital* component, through its classic calming action, helps control irritability and anxiety, and helps counteract excessive CNS stimulation.

Also available: Ambar #1 Extentabs®—methamphetamine hydrochloride 10 mg., phenobarbital 64.8 mg. (1 gr.) (Warning: may be habit forming).

BRIEF SUMMARY / *Indications:* Ambar suppresses appetite and helps offset emotional reactions to dieting. *Side Effects:* Nervousness or excitement occasionally noted, but usually infrequent at recommended dosages. Slight drowsiness has been reported rarely. *Precautions:* Administer with caution in the presence of cardiovascular disease or hypertension. *Contraindications:* Hypersensitivity to barbiturates or sympathomimetics; patients with advanced renal or hepatic disease. See package insert for further details.


How long will it take him
to recover from the flu
if he just doesn't care?

**Does he really care? Is he alert, encouraged, positive and optimistic about getting out of bed and back to work soon?**

**Or is he giving in to the depressing impact of confinement?**

**When functional fatigue complicates convalescence, Alertonic can help...**

Pleasant-tasting Alertonic is pipradrol hydrochloride—an effective cerebral stimulant whose gentle analeptic action helps counteract the apathy and inertia that so often delay convalescence—together with an excellent vitamin and mineral formula, in a satisfying 15% alcohol vehicle.

Nothing fosters confidence and a sense of well-being better than your own personal warmth, understanding and encouragement together with Alertonic to help insure prompt response.

*Adequate dosage is important: Prescribe Alertonic—one tablespoonful t.i.d., 30 minutes before meals...tastes best chilled.*

*And for your patient's sake, prescribe Alertonic in the convenient, economical one-pint bottle.*

# Alertonic®

*Available Only On Prescription*

Each 45 cc. (3 tablespoonfuls) contains: alcohol, 15%; pipradrol hydrochloride, 2 mg.; thiamine hydrochloride (vitamin $B_1$) (10 MDR*), 10 mg.; riboflavin (vitamin $B_2$) (4 MDR), 5 mg.; pyridoxine hydrochloride (vitamin $B_6$), 1 mg.; niacinamide (5 MDR), 50 mg.; choline,† 100 mg.; inositol,† 100 mg.; calcium glycerophosphate, 100 mg. (supplies 2% MDR for calcium and for phosphorus) and 1 mg. each of the following: cobalt (as chloride), manganese (as sulfate), magnesium (as acetate), zinc (as acetate), and molybdenum (as ammonium molybdate).

*Multiple of adult Minimum Daily Requirement supplied.
†The need for these substances in human nutrition has not been established.

***Indications:*** 1. Functional fatigue such as that often associated with: a depressing life experience or stressful time of life; advancing years; convalescence; limited activity or confinement. 2. Poor appetite and vitamin-mineral deficiency as they occur in: patients having faulty eating habits; geriatric patients who are losing interest in food; patients convalescing from debilitating illness or surgery.

***Contraindications:*** As with other drugs with CNS stimulating action, Alertonic is contraindicated in hyperactive, agitated or severely anxious patients and in chorea or obsessive compulsive states.

***Side effects:*** Reports of overstimulation have been rare. Patients who are known to be unduly sensitive to the effects of stimulant drugs should be observed carefully in the initial stages of treatment.

***Dosage:*** Adults, 1 tablespoonful; children (over 15 years old), 1 to 2 teaspoonfuls; children (4 to 15 years old), 1 teaspoonful. To be taken three times daily 30 minutes before meals.

Merrell

THE WM. S. MERRELL COMPANY
Division of Richardson-Merrell Inc.
Cincinnati, Ohio 45215

6-7907

# Norinyl® tablets

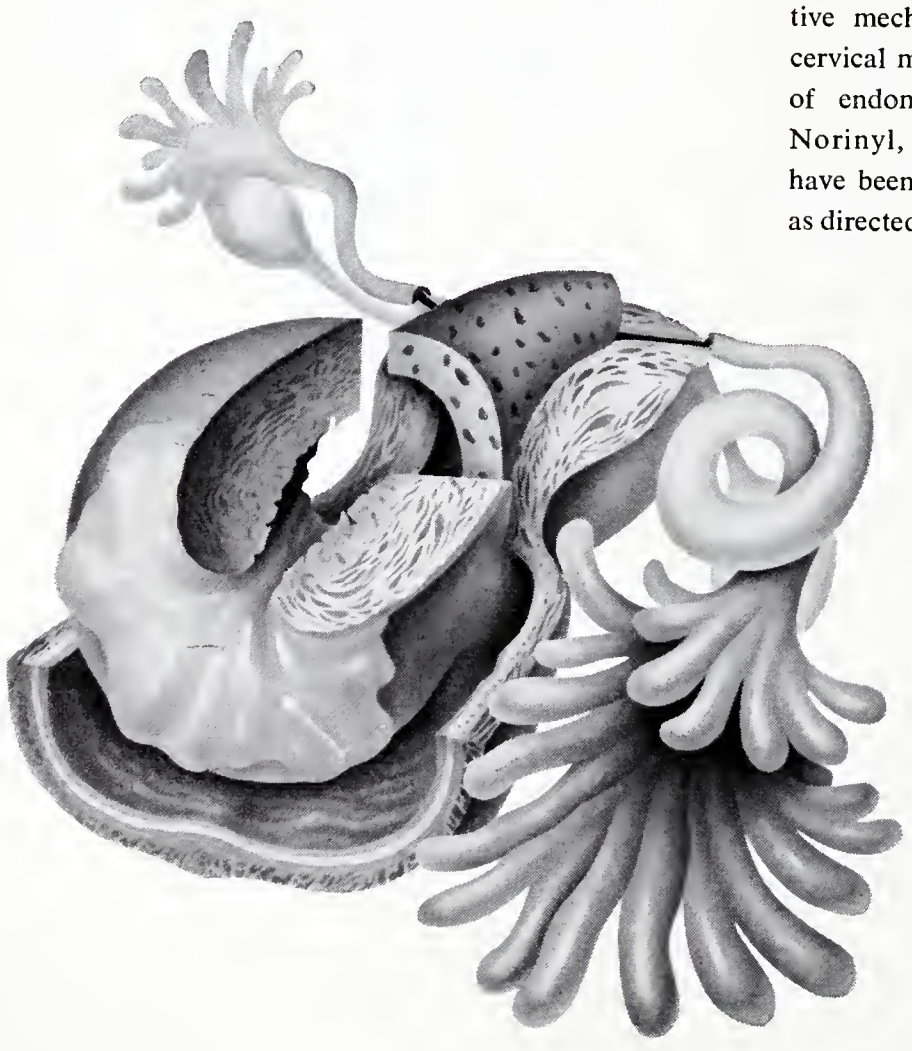
(norethindrone 2 mg. ± mestranol 0.1 mg.)

# for multiple contraceptive action that has produced a record of unexcelled effectiveness

**inhibition of ovulation by means of 2 time-proved hormonal agents**

**production of a cervical mucus hostile to sperm motility and vitality**

**creation of an endometrium unreceptive to egg implantation**



**no unplanned pregnancies**

Norinyl provides multiple action for maximum assurance of success. It does not depend on ovulation inhibition alone for contraceptive effectiveness. The mechanism of action of combined hormonal therapy results in ovulation inhibition reinforced by other protective mechanisms, including a hostile cervical mucus[1-13] and an acceleration of endometrial changes.[1-3,7-16] With Norinyl, no unplanned pregnancies have been reported to date when used as directed.

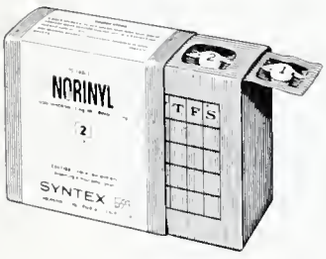
# plus important supportive benefits that help her through those critical early months of oral contraception

**low incidence of side effects**

Low incidence of BTB and spotting, nausea and amenorrhea tends to minimize side effect problems and increases patient cooperation.

**no confusion about dosage**

An unbreakable "confusionproof" package makes it easy to adhere to prescribed dosage schedule: individually sealed tablets numbered from 1 through 20 *plus* monthly calendar record enables patient to double-check dosage intake by day and corresponding tablet number.




**Contraindications**: Thrombophlebitis or pulmonary embolism (current or past). Existing evidence does not support a causal relationship between use of Norinyl and development of thromboembolism. While a study which was conducted does not resolve definitively the possible etiologic relationship between progestational agents and intravascular clotting, it tends to confirm the findings of the Ad Hoc Advisory Committee appointed by the Food and Drug Administration to review this possibility. Cardiac, renal or hepatic dysfunction. Carcinoma of the breast or genital tract. Patients with a history of psychic depression should be carefully studied and the drug discontinued if depression recurs to marked degree. Patients with a history of cerebral vascular accident.

**Warning**: Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions, medication should be withdrawn.

**Precautions**: By May 1963, experience with norethindrone 2 mg.—mestranol 0.1 mg. had extended over 24 months. Through miscalculation, omission or error in taking the recommended dosage of Norinyl, pregnancy may result. If regular menses fail to appear and treatment schedule has not been adhered to, or if patient misses two menstrual periods, possibility of pregnancy should be resolved before resuming Norinyl. If pregnancy is established, Norinyl should be discontinued during period of gestation since virilization of the female fetus has been reported with oral use of progestational agents or estrogen. When lactation is desired, withhold Norinyl until nursing needs are established. Existing uterine fibroids may increase in size. In metabolic or endocrine disorders, careful clinical preevaluation is indicated. A few patients without evidence of hyperthyroidism had elevated serum protein-bound iodine levels, which in the light of present knowledge, does not necessarily imply hyperthyroidism. Protein-bound iodine increased following estrogen administration. Bromsulphalein retention has occurred in up to 25% of patients without evidence of hepatic dysfunction. Studies from 24-hour urine collections have shown an increase in aldosterone and 17-ketosteroids and decrease in 17-hydroxycorticoid levels. Thus, Norinyl should be discontinued prior to and during thyroid, liver or adrenal function tests. Because progestational agents may cause fluid retention, conditions such as epilepsy, migraine and asthma require careful observation. Thus far no deleterious effect on pituitary, ovarian or adrenal function has been noted; however, long-range possible effect on these and other organs must await more prolonged observation. Norinyl should be used with caution in patients with bone, renal or any disease involving calcium or phosphorus metabolism.

**Side Effects**: Intermenstrual bleeding; amenorrhea; symptoms resembling early pregnancy, such as nausea, breast engorgement or enlargement, chloasma and minor degree of fluid retention (if these should occur and patient has not strictly adhered to medication plan, she should be tested for pregnancy); weight gain; subjective complaints such as headache, dizziness, nervousness, irritability; in a few patients libido was increased. In a total of 3,090 patients, 2.2% discontinued medication because of nausea.

NOTE: See sections on contraindications and precautions for possible side effects on other organ systems.

**Dosage and Administration**: One Norinyl tablet orally for 20 days, commencing on day 5 through and including day 24 of the menstrual cycle. (Day 1 is the first day of menstrual bleeding.)

**Availability**: Dispensers of 20 and 60 tablets; bottles of 100.

**References:** 1. Council on Drugs. JAMA 187:664 (Feb. 29) 1964 2. Bryans, F. E.: Canad Med Ass J 92:287 (Feb 6) 1965. 3. Goldzieher, J. W : Med Clin N Amer 48:529 (Mar.) 1964. 4. Cohen, M. R : Paper presented at Symposium on Low-Dosage Oral Contraception, Palo Alto, Calif., July 15, 1965. Reported in Med Sci 16:26 (Nov.) 1965. 5. Hammond, D. O.: Ibid 6. Rice-Wray, E., Goldzieher, J. W., and Aranda-Rosell, A · Fertil Steril 14:402 (Jul.-Aug ) 1963 7. Goldzieher, J. W., Moses, L. E., and Ellis, L. T.: JAMA 180:359 (May 5) 1962 8. Kempers, R. D.: GP 29:88 (Jan ) 1964 9. Tyler, E. T.: JAMA 187.562 (Feb. 22) 1964 10. Rudel, H. W., Martinez-Manautou, J., and Maqueo-Topete, M · Fertil Steril 16·158 (Mar · Apr.) 1965. 11. Flowers, C. E., Jr.: N Carolina Med J 25:139 (Apr.) 1964. 12. Goldzieher, J. W.: Appl Ther 6·503 (June) 1964. 13. The Control of Fertility. Report adopted by the Committee on Human Reproduction of the American Medical Association. JAMA 194·462 (Oct. 25) 1965. 14. Flowers, C. E., Jr.: JAMA 188:1115 (June 29) 1964 15. Merritt, R. I.: Appl Ther 6:427 (May) 1964 16. Newland, D. O.: Paper presented at Symposium on Low-Dosage Oral Contraception, Palo Alto, Calif., July 15, 1965. Reported in Med Sci 16:26 (Nov.) 1965.

norethindrone—an original steroid from
SYNTEX
LABORATORIES INC., PALO ALTO, CALIF

# Norinyl® tablets

(norethindrone 2 mg ē mestranol 0.1 mg)

**for multiple contraceptive action**



# Meet the M6... it goes like 90

The Kodak RP X-omat Processor, Model M6, the first automatic processor designed exclusively for 90-second processing.

If you're planning a new installation, the comt M6 is the easy, convenient way to get the ter service, smoother patient traffic flow, ater capacity, and new efficiency of the Kodak X-omat® System.

For a processor that takes up only 4.6 square t of floor space in the lighted area, the M6 es a big job, processing dry-to-dry 350 sheets of n per hour, average of intermixed sizes.

Because of its 90-second dry-to-dry delivery e and large capacity, it is the answer to today's d tomorrow's) film-processing needs.

All important, the Kodak RP X-omat System ures uniform processing that results in excellent quality radiographs time after time.

Kodak RP X-omat Medical X-ray Film gives you speed and contrast that equal famed Kodak Blue Brand Film.

Kodak RP/S X-omat Medical X-ray Film has higher contrast, permits shorter exposures.

Both films have the sheet-to-sheet uniformity Kodak designs into *all* its radiography products.

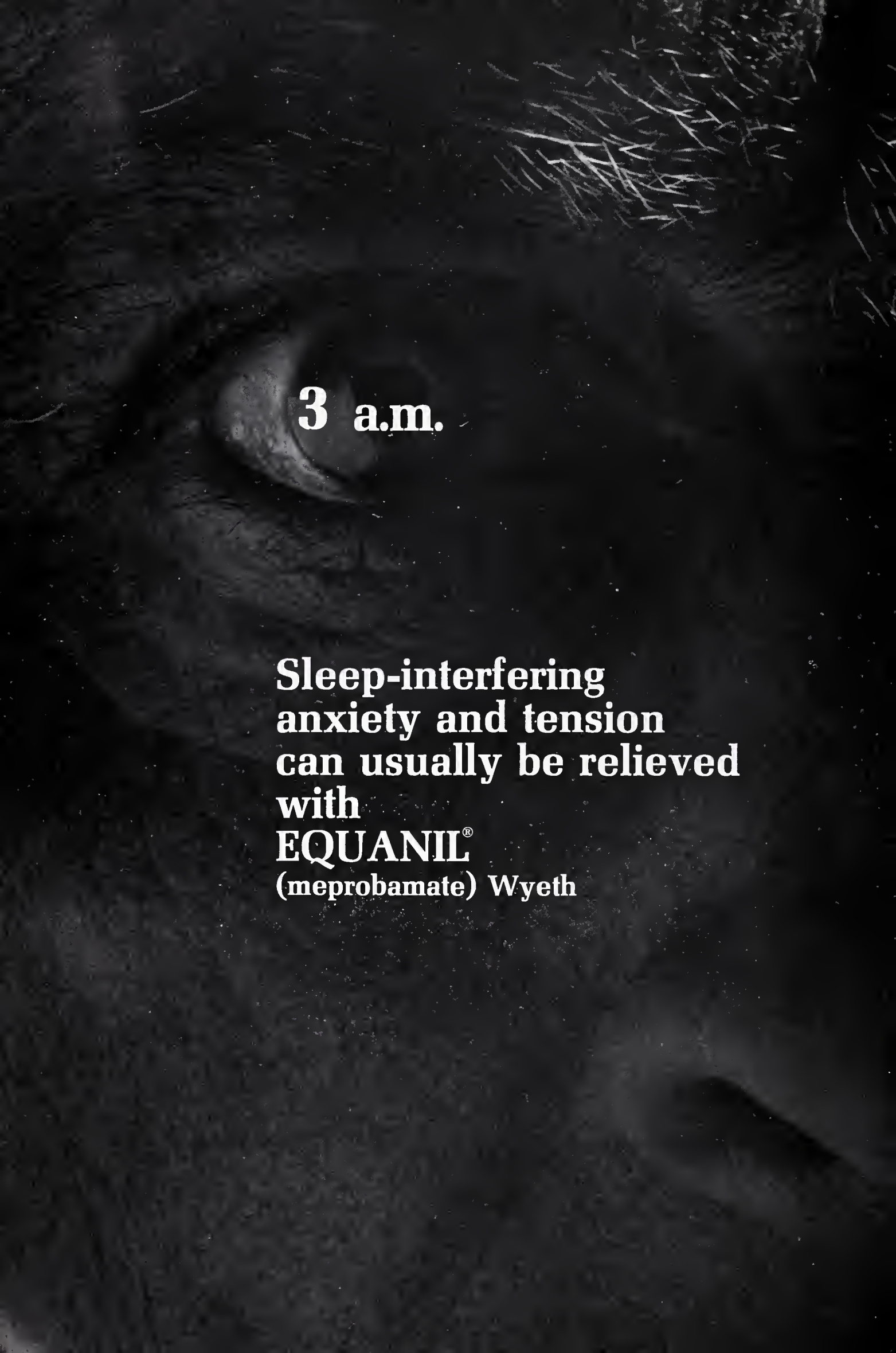
You can order the new Kodak RP X-omat Processor, Model M6, for new installations and expanding facilities.

Or convert most existing X-omat Processors to this time-saving 90-second cycle.

Ask your Kodak X-omat dealer or Kodak Technical Sales Representative for detailed information about planning, installation, and service on the Kodak RP X-omat System.

**EASTMAN KODAK COMPANY**
**Radiography Markets Division**
**Rochester, N.Y.**

Kodak
TRADEMARK


3 a.m.
Sleep-interfering
anxiety and tension
can usually be relieved
with
EQUANIL®
(meprobamate) Wyeth



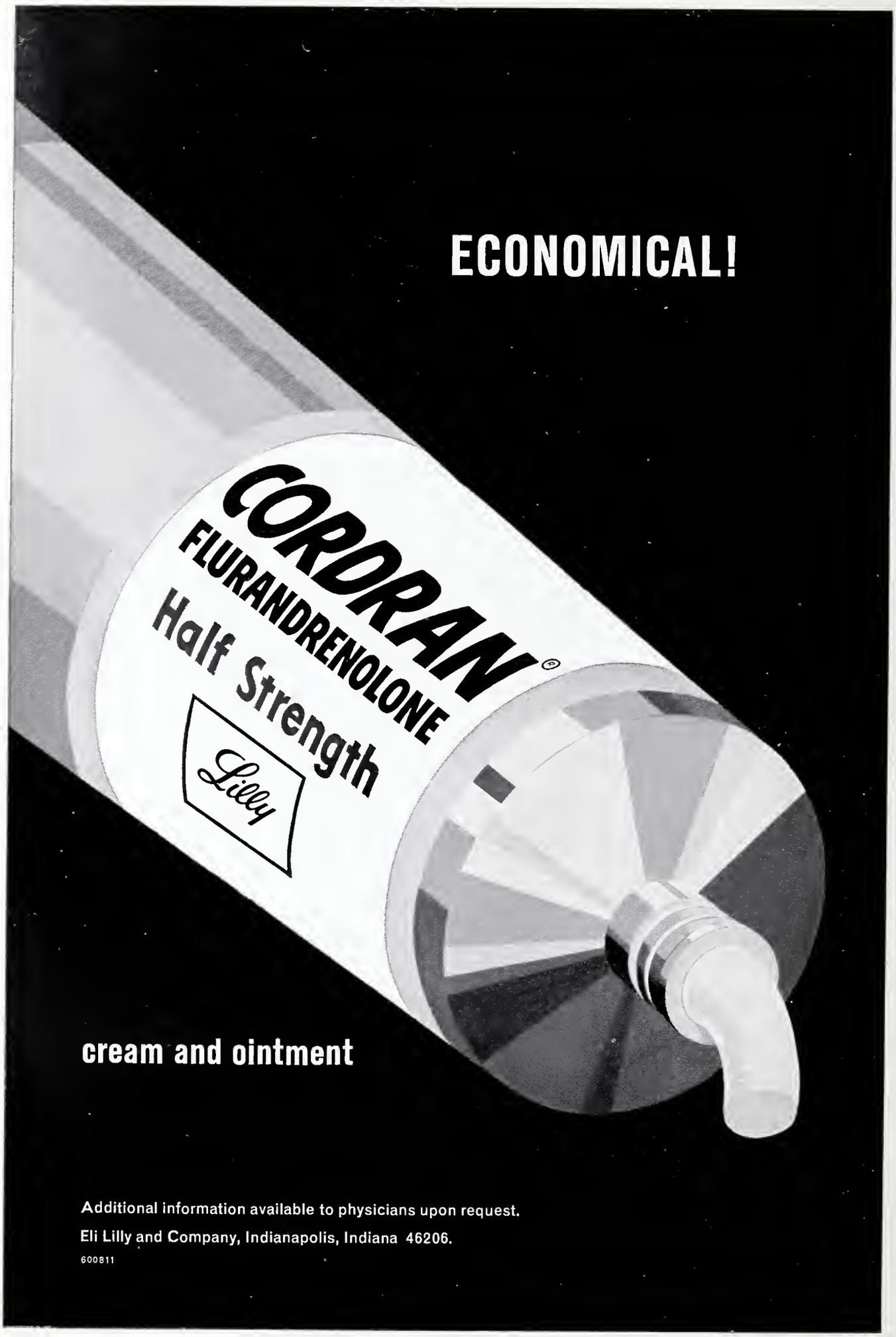
**Cautions:** Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use may result in dependence or habituation in susceptible persons—as ex-addicts, alcoholics, severe psychoneurotics. After prolonged high dosage, drug should be withdrawn gradually to avoid possibly severe withdrawal reactions including epileptiform seizures. Side effects include drowsiness and, rarely, allergic or idiosyncratic reactions. These reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Mild reactions are characterized by urticarial or erythematous maculopapular rash. Acute non-thrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever have been reported. Meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioneurotic edema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. Warn patients of possible reduced alcohol tolerance. Should drowsiness, ataxia, or visual disturbances occur, dose should be reduced. If symptoms persist, patients should not operate vehicles or dangerous machinery. A few cases of leukopenia, usually transient, have been reported following prolonged dosage. Other blood dyscrasias—aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis and hemolytic anemia—have occurred rarely, almost always in the presence of known toxic agents. One fatal case of bullous dermatitis following intermittent use of meprobamate with prednisolone has been reported. Prescribe very cautiously for patients with suicidal tendencies. Suicidal attempts should be treated with immediate gastric lavage and appropriate supportive therapy.

**Contraindications:** History of sensitivity to meprobamate.

**Composition:** Tablets, 200 mg. and 400 mg. meprobamate. Coated Tablets, WYSEALS® EQUANIL (meprobamate) 400 mg. Continuous-Release Capsules, EQUANIL L-A (meprobamate) 400 mg.

Wyeth Laboratories
Philadelphia, Pa.

Wyeth®
SERVICE TO MEDICINE


ECONOMICAL!
CORDRAN®
FLURANDRENOLONE
Half Strength
Lilly
cream and ointment
Additional information available to physicians upon request.
Eli Lilly and Company, Indianapolis, Indiana 46206.
600811

*Statistics confirm the impression that hospitalization for mental illness in Hawaii is mainly for treatment, not custody.*

# Ten-Year Profile of Hawaii State Hospital: A Statistical Analysis

HOWARD E. GUDEMAN, Ph.D., *Honolulu*

• *Despite a rising population, and an increased number of readmissions to Hawaii State Hospital, the hospital census has dropped from about 1,200 (through 1958) to about 1,000 (since 1962). A fall of new admissions from an average of 286 (1954-59) to an average of 270 (1960-64), and shortening of the average stay, seems to have produced this change despite a corresponding increase of average annual readmissions, in these two five-year periods, from 260 to 346. Unauthorized departures from the hospital, which totaled from three per cent of total releases in 1955-58, and just over five per cent in 1959-61, leaped to nearly 20 per cent in 1963-64, suggesting that the community, and therefore the hospital administration, has a more relaxed and permissive attitude toward this problem nowadays. Of the 478 patients admitted for the first time during this decade, and included in this sample, only five were never discharged.*

THE DECADE from July 1, 1954, to June 30, 1964, brought significant changes to many mental hospitals throughout the mainland and to the Hawaii State Hospital. For the first time, steady expansion of the resident patient population was halted and actually reversed. A combination of factors, including primarily chemotherapy and social psychiatry, enabled the mental hospital to change from a custodial institution to a more active treatment center.

Received for publication December 15, 1965.

This report attempts to trace some of the changes that have occurred at the Hawaii State Hospital during this ten-year period, and to note some of the implications of these changes.

## PATIENT RESIDENT POPULATION AND MOVEMENT

One of the most obvious changes at the Hawaii State Hospital is a reduction in the resident patient population. There has been a 20 per cent decrease (Table 1) in the number of patients actually residing in the hospital. Although the number of resident patients has decreased, the number of patients coming into the hospital has steadily increased. About 15 per cent more people entered the hospital in 1964-65 than in 1953-54. Thus the "locked doors" of the Hawaii State Hospital seem to have become "revolving doors" that allow freer passage both to and from the hospital.

TABLE 1.—*Resident Population and Patient Movement—1954-64.*

| FISCAL YEAR | HOSPITAL POPULATION JUNE 30 | TOTAL ADDITIONS | TOTAL RELEASES | TOTAL MOVEMENT IN AND OUT |
|---|---|---|---|---|
| 1954-55 | 1219 | 598 | 558 | 1156 |
| 1955-56 | 1208 | 542 | 550 | 1092 |
| 1956-57 | 1228 | 526 | 506 | 1032 |
| 1957-58 | 1241 | 541 | 527 | 1068 |
| 1958-59 | 1176 | 484 | 548 | 1032 |
| 1959-60 | 1170 | 527 | 533 | 1060 |
| 1960-61 | 1180 | 593 | 583 | 1176 |
| 1961-62 | 1129 | 650 | 701 | 1351 |
| 1962-63 | 1053 | 715 | 791 | 1506 |
| 1963-64 | 978 | 676 | 761 | 1437 |

TABLE 2.—*Patient Commitment Procedures—1954-64.*

| FISCAL YEAR | TOTAL ADMISSIONS | COURT | | VOLUNTARY | | TRANSFER AND OBSERVATION | |
|---|---|---|---|---|---|---|---|
| | N | N | % | N | % | N | % |
| 1954-55 | 435 | 384 | 88 | 28 | 06 | 23 | 05 |
| 1955-56 | 396 | 362 | 91 | 14 | 04 | 20 | 05 |
| 1956-57 | 351 | 311 | 89 | 32 | 09 | 8 | 02 |
| 1957-58 | 378 | 267 | 71 | 101 | 27 | 10 | 03 |
| 1958-59 | 351 | 252 | 72 | 85 | 24 | 14 | 04 |
| 1959-60 | 377 | 289 | 74 | 83 | 21 | 5 | 05 |
| 1960-61 | 449 | 342 | 76 | 80 | 18 | 27 | 06 |
| 1961-62 | 471 | 319 | 68 | 139 | 30 | 13 | 02 |
| 1962-63 | 456 | 265 | 58 | 169 | 37 | 22 | 05 |
| 1963-64 | 432 | 254 | 59 | 165 | 38 | 13 | 03 |
| Total | 4096 | 3045 | 74 | 896 | 22 | 127 | 03 |

TABLE 3.—*Sex of Additions to Population—1954-64.*

| FISCAL YEAR | FEMALE | | MALE | | TOTAL ADDITIONS |
|---|---|---|---|---|---|
| | N | % | N | % | |
| 1954-55 | 220 | 37 | 378 | 63 | 598 |
| 1955-56 | 217 | 40 | 325 | 60 | 542 |
| 1956-57 | 244 | 46 | 282 | 54 | 526 |
| 1957-58 | 231 | 43 | 310 | 57 | 541 |
| 1958-59 | 217 | 45 | 267 | 55 | 484 |
| 1959-60 | 238 | 45 | 289 | 55 | 527 |
| 1960-61 | 266 | 45 | 327 | 55 | 593 |
| 1961-62 | 289 | 44 | 361 | 56 | 650 |
| 1962-63 | 325 | 45 | 390 | 55 | 715 |
| 1963-64 | 318 | 47 | 358 | 53 | 676 |
| Total | 2565 | 44 | 3287 | 56 | 5852 |

The implications of these figures are important for program planning. The period immediately following admission and the period immediately preceding discharge require the greatest amount of time and energy from the hospital staff. Diagnostic formulations, treatment plans and programs, placement plans, and discharge interviews add additional work to the routine care and treatment provided resident patients, and require additional staff time and energy. Thus, although fewer patients reside in the hospital at any one time, the staff actually has more work because of the increased transiency of the population.

## COMMITMENT PROCEDURES

The manner in which a person becomes a patient in a mental hospital has implications for his hospital adjustment and further reflects a community's attitude toward mental disorders. In the ten-year period there has been a change in commitment procedures. Table 2 gives the number and percentage of patients coming into Hawaii State Hospital on a voluntary basis and those who have had to endure legal procedures to reach the hospital. Although most are still committed, voluntary admissions are increasing.

A court commitment carries a coercive and negative connotation and frequently involves police action as a result of antisocial behavior. A voluntary commitment implies that the patient is reasonable and responsible.

This shift in commitment procedures is considered to be a reflection of our culture's changing attitude toward mental illness. As this trend increases and as the general population moves to and from the mental hospital as easily as to and from the general medical hospital, a great deal of the stigma attached to being a mental hospital patient may be lost.

Yet another important psychological implication needs to be stressed. When a person feels—even in part—responsible for a decision, he is more apt to work in conjunction with this decision, whereas he might be ready to sabotage a program imposed upon him by a decision for which he feels no responsibility. Thus the voluntary patient is more able to accept his treatment program and participate in its planning. Eventually, it can be anticipated, most mental patients may arrive at the hospital on a voluntary basis.

## SEX, AGE, AND ETHNIC CHARACTERISTICS OF PATIENTS

The sex, age, and ethnic background of patients coming into a mental hospital are rather

TABLE 4.—*Age of Additions to Population—1954-64.*

| FISCAL YEAR | UNDER 15 | | 15-24 | | 25-34 | | 35-44 | | 45-54 | | 55-64 | | 65 & OVER | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | N | % | N | % | N | % | N | % | N | % | N | % | N | % |
| 1954-55 | 2 | 01 | 82 | 13 | 180 | 30 | 141 | 24 | 86 | 14 | 52 | 09 | 55 | 09 |
| 1955-56 | 1 | 01 | 73 | 13 | 143 | 26 | 133 | 25 | 87 | 16 | 49 | 09 | 56 | 10 |
| 1956-57 | 5 | 01 | 70 | 13 | 143 | 27 | 121 | 23 | 99 | 19 | 47 | 09 | 41 | 08 |
| 1957-58 | 10 | 02 | 62 | 11 | 121 | 22 | 153 | 28 | 98 | 18 | 55 | 10 | 42 | 09 |
| 1958-59 | 3 | 01 | 69 | 14 | 111 | 23 | 116 | 24 | 102 | 21 | 46 | 10 | 32 | 07 |
| 1959-60 | 0 | 00 | 72 | 14 | 128 | 24 | 120 | 23 | 97 | 18 | 55 | 10 | 54 | 11 |
| 1960-61 | 5 | 01 | 94 | 16 | 158 | 27 | 140 | 24 | 94 | 16 | 61 | 10 | 40 | 06 |
| 1961-62 | 12 | 02 | 112 | 17 | 167 | 26 | 156 | 24 | 99 | 15 | 53 | 08 | 51 | 08 |
| 1962-63 | 8 | 01 | 93 | 13 | 189 | 26 | 167 | 23 | 130 | 18 | 65 | 09 | 63 | 10 |
| 1963-64 | 6 | 01 | 82 | 12 | 175 | 26 | 172 | 26 | 108 | 16 | 64 | 09 | 67 | 10 |
| Total | 52 | 01 | 809 | 14 | 1515 | 26 | 1419 | 24 | 1000 | 17 | 547 | 09 | 501 | 09 |

TABLE 5.—*Ethnic Background of Additions to Population—1954-64.*

| FISCAL YEAR | CHINESE | | CAUCASIAN | | FILIPINO | | JAPANESE | | HAWAIIAN | | PART-HAWAIIAN | | ALL OTHER | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | N | % | N | % | N | % | N | % | N | % | N | % | N | % |
| 1954-55 | 26 | 04 | 172 | 29 | 87 | 15 | 182 | 30 | 27 | 05 | 55 | 09 | 35 | 08 |
| 1955-56 | 31 | 06 | 152 | 28 | 83 | 15 | 154 | 28 | 24 | 04 | 56 | 10 | 42 | 09 |
| 1956-57 | 23 | 04 | 153 | 29 | 73 | 14 | 172 | 33 | 27 | 05 | 45 | 09 | 33 | 06 |
| 1957-58 | 17 | 03 | 145 | 27 | 94 | 17 | 167 | 31 | 24 | 04 | 59 | 11 | 35 | 07 |
| 9158-59 | 18 | 04 | 155 | 32 | 77 | 16 | 126 | 26 | 15 | 04 | 60 | 12 | 33 | 06 |
| 1959-60 | 23 | 04 | 168 | 32 | 69 | 13 | 152 | 29 | 18 | 03 | 67 | 13 | 30 | 06 |
| 1960-61 | 24 | 04 | 201 | 34 | 65 | 11 | 179 | 30 | 11 | 02 | 79 | 13 | 34 | 06 |
| 1961-62 | 22 | 03 | 212 | 33 | 66 | 10 | 200 | 31 | 17 | 03 | 77 | 12 | 56 | 08 |
| 1962-63 | 27 | 04 | 224 | 31 | 90 | 13 | 198 | 28 | 14 | 02 | 95 | 13 | 67 | 09 |
| 1963-64 | 28 | 04 | 231 | 34 | 65 | 10 | 198 | 29 | 19 | 03 | 82 | 12 | 53 | 08 |
| Total | 239 | 04 | 1813 | 32 | 769 | 13 | 1728 | 30 | 196 | 03 | 675 | 12 | 418 | 06 |

stable statistics. Changes in these statistics would tend to reflect changing administrative policy, or changes in the population from which the hospital draws its patients. Consequently, in order that programs may continue to give optimal care and treatment, the hospital staff needs to be aware of any changes in these statistics.

*Sex:* In the Hawaii State Hospital population males have always outnumbered the female patients. This is still true, but in this ten-year period there has been a progressive trend toward equalization of the sexes (Table 3).

*Age:* During this ten-year period, there has been no significant change in the age of patients coming into the hospital. Table 4 gives the actual numbers for each age group and the percentage of the total they represent. As can be seen by the table, approximately half of the patients coming into the hospital for the decade have been between 25 and 45 years of age.

*Ethnic Background:* Table 5 presents the ethnic background of the patients coming into Hawaii State Hospital for the ten-year period. Again, as with age, there has been no substantial change in the representation of the various groups. It is anticipated that as the ethnic representation in the general population is modified, this change will be reflected in the hospital population. That is, if the percentage of Caucasians continues to increase in the community, their representation in the hospital will also increase. Although suggested, this trend is not established in these statistics.

## DIAGNOSES OF FIRST ADMISSIONS

Table 6 shows the diagnoses given to patients admitted to Hawaii State Hospital for the first time in the period from 1954-55 to 1962-63. Although there are fluctuations in these statistics there has not been a substantial and consistent modification or trend. The largest group of patients is given a diagnosis of schizophrenia. Another substantial group consists of patients diagnosed as having a brain syndrome. The consistency of these statistics throughout the ten-year period seems surprising, particularly in face of the fluctuating staff that has characterized this period and also of the "fickleness" with which diagnosis is held.

A related aspect of Table 6 warrants mention. The percentage of patients who were given a diagnosis other than those listed in the American Psychiatric Association approved nomenclature, or those undiagnosed, ranged from four per cent in

TABLE 6.—*Diagnoses of First Admissions—1954-64.*

| FISCAL YEAR | BRAIN SYNDROME | | MENTAL DEFICIENCY | | AFFECTIVE DISORDER | | SCHIZOPHRENIA | | NEUROSIS | | PERSONALITY DISORDER | | OTHER & UNDIAG. | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | N | % | N | % | N | % | N | % | N | % | N | % | N | % |
| 1954-55 | 69 | 21 | 5 | 02 | 27 | 08 | 113 | 35 | 7 | 02 | 58 | 18 | 46 | 14 |
| 1955-56 | 69 | 25 | 3 | 02 | 20 | 07 | 115 | 41 | 11 | 04 | 29 | 10 | 31 | 11 |
| 1956-57 | 54 | 20 | 1 | 01 | 20 | 08 | 87 | 33 | 10 | 04 | 41 | 16 | 48 | 18 |
| 1957-58 | 60 | 22 | 5 | 01 | 21 | 08 | 130 | 47 | 13 | 05 | 35 | 13 | 12 | 04 |
| 1958-59 | 30 | 14 | 1 | 01 | 19 | 09 | 83 | 38 | 9 | 04 | 33 | 14 | 46 | 20 |
| 1959-60 | 60 | 24 | 2 | 01 | 17 | 07 | 71 | 28 | 7 | 03 | 36 | 14 | 59 | 23 |
| 1960-61 | 50 | 18 | 9 | 03 | 16 | 06 | 71 | 25 | 6 | 02 | 36 | 13 | 100 | 35 |
| 1961-62 | 68 | 22 | 5 | 01 | 17 | 06 | 117 | 38 | 15 | 05 | 48 | 16 | 37 | 12 |
| 1962-63 | 69 | 24 | 6 | 02 | 16 | 06 | 113 | 39 | 20 | 07 | 36 | 12 | 29 | 10 |
| 1963-64 | 94 | 32 | 7 | 02 | 22 | 08 | 87 | 30 | 33 | 11 | 47 | 14 | 10 | 03 |
| Total | 623 | 23 | 44 | 02 | 195 | 07 | 987 | 35 | 131 | 05 | 394 | 14 | 418 | 14 |

TABLE 7.—*Admissions, Readmissions and Returns—1954-64.*

| FISCAL YEAR | FIRST ADMISSIONS | | READMISSIONS & RET. FROM C.D. | | TOTAL ADDITIONS |
|---|---|---|---|---|---|
| | N | % | N | % | N |
| 1954-55 | 325 | 54 | 273 | 46 | 598 |
| 1955-56 | 278 | 51 | 264 | 49 | 542 |
| 1956-57 | 261 | 50 | 265 | 50 | 526 |
| 1957-58 | 276 | 51 | 265 | 49 | 541 |
| 1958-59 | 221 | 46 | 263 | 54 | 484 |
| 1959-60 | 252 | 48 | 275 | 52 | 527 |
| 1960-61 | 289 | 49 | 304 | 51 | 593 |
| 1961-62 | 307 | 47 | 343 | 53 | 650 |
| 1962-63 | 289 | 40 | 426 | 60 | 715 |
| 1963-64 | 292 | 43 | 384 | 57 | 676 |
| Total | 2790 | 48 | 3062 | 52 | 5852 |

1957-58 to 35 per cent in 1960-61. The percentage of patients diagnosed "Schizophrenic Reaction" ranged from 47 per cent in 1957-58 to 25 per cent in 1960-61. This discrepancy alone makes one suspect statistics based solely on diagnosis. It may be observed that during this period the number of schizophrenics decreased 22 per cent while the number of other and undiagnosed increased 31 per cent. Thus there may be a relationship between those diagnosed schizophrenic and those undiagnosed or given an unconventional diagnosis.

### ADDITIONS TO HAWAII STATE HOSPITAL

Table 7 gives the number and percentage of patients coming into the hospital more than once. From this table one sees an 11 per cent decrease in new additions and an 11 per cent increase in those readmitted or returned from conditional discharge.

The implications of these statistics are twofold and interrelated. They suggest that the majority of people coming into the hospital in 1963-64 have been there before, in contrast to ten years earlier when the majority of those coming into the hospital were there for the first time. Thus, the staff of the Hawaii State Hospital is spending more and more time working with the same group of patients.

Therefore, an increasing problem faced by the hospital staff is to develop effective programs to deal with patients experiencing repeated hospitalizations, as well as to provide programs for those arriving for the first time. This is not simply the matter of providing treatment programs for chronic patients versus acute patients. In many cases patients return because of an exacerbation of an acute episode rather than a progression into chronicity. The difference is primarily that many patients who frequently return to the hospital have periods of remission from psychosis. These patients represent a segment of the population that the hospital and other mental health agencies need to understand more adequately in order to deal with more effectively.

Another implication of these statistics, although one not adequately substantiated for conclusive statement, is that community resources, public and private clinics, and practitioners are dealing more effectively with potential patients and thereby precluding their hospitalization. The decreasing percentage of first admissions, as well as the decrease in actual number in face of a rising population in the community, suggests this possibility.

### RELEASES FROM HAWAII STATE HOSPITAL

An examination of the methods by which patients leave the hospital indicates that the actual number of patients receiving full discharge and conditional discharge is increasing. However, percentagewise there seems to be no significant trend or modification. This seems surprising, particularly when a greater number and percentage of patients have come in on a voluntary basis (Table 2). It would be appropriate and desirable that the proportion of patients receiving full discharge rather than conditional discharge also shows an increase. Recent policy changes (Spring, 1964) deal with this issue, and it is anticipated that future statistics will show a marked increase in full discharges and a marked decrease in conditional discharges.

TABLE 8.—*Releases and AWOL's—1954-64.*

| FISCAL YEAR | FULL DISCHARGE | | CONDITIONAL DISCHARGE | | DECEASED | | TOTAL RELEASES | AWOL (ESCAPES) |
|---|---|---|---|---|---|---|---|---|
| | N | % | N | % | N | % | N | N |
| 1954-55 | 110 | 20 | 386 | 69 | 62 | 11 | 558 | 4 |
| 1955-56 | 125 | 23 | 351 | 64 | 74 | 13 | 550 | 18 |
| 1956-57 | 118 | 23 | 327 | 65 | 61 | 12 | 506 | 17 |
| 1957-58 | 111 | 21 | 350 | 66 | 66 | 13 | 527 | 14 |
| 1958-59 | 120 | 22 | 385 | 70 | 43 | 08 | 548 | 29 |
| 1959-60 | 140 | 26 | 321 | 60 | 72 | 14 | 533 | 28 |
| 1960-61 | 170 | 29 | 360 | 62 | 53 | 09 | 583 | 40 |
| 1961-62 | 192 | 27 | 451 | 64 | 58 | 09 | 701 | 37 |
| 1962-63 | 195 | 25 | 526 | 66 | 70 | 09 | 791 | 46 |
| 1963-64 | 217 | 29 | 484 | 64 | 56 | 07 | 757 | 145 |
| Total | 1498 | 25 | 3941 | 65 | 615 | 10 | 6054 | |

TABLE 9.—*Length of First Hospitalization—1954-63.*

| YEAR | TOTAL ADMISSIONS | SIX MONTHS AFTER ADMISSION | | | | | | ONE YEAR AFTER ADMISSION | | | | | | TWO YEARS AFTER ADMISSION | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | NUMBER DISCHARGED | | NUMBER RETAINED | | NUMBER DEAD | | NUMBER DISCHARGED | | NUMBER RETAINED | | NUMBER DEAD | | NUMBER DISCHARGED | | NUMBER RETAINED | | NUMBER DEAD | |
| | N | N | % | N | % | N | % | N | % | N | % | N | % | N | % | N | % | N | % |
| 1954 | 47 | 27 | 58 | 17 | 36 | 3 | 06 | 33 | 70 | 10 | 21 | 4 | 09 | 35 | 74 | 7 | 15 | 5 | 11 |
| 1955 | 42 | 23 | 55 | 18 | 43 | 1 | 02 | 34 | 81 | 7 | 17 | 1 | 02 | 38 | 90 | 2 | 05 | 2 | 05 |
| 1956 | 54 | 28 | 52 | 21 | 39 | 5 | 09 | 37 | 69 | 11 | 20 | 6 | 11 | 38 | 70 | 10 | 19 | 6 | 11 |
| 1957 | 45 | 19 | 42 | 25 | 56 | 1 | 02 | 32 | 71 | 11 | 24 | 2 | 05 | 37 | 82 | 5 | 11 | 3 | 07 |
| 1958 | 44 | 28 | 66 | 12 | 27 | 3 | 07 | 34 | 77 | 7 | 16 | 3 | 07 | 34 | 77 | 4 | 09 | 6 | 14 |
| 1959 | 44 | 26 | 59 | 17 | 39 | 1 | 02 | 37 | 84 | 5 | 11 | 2 | 05 | 39 | 89 | 3 | 07 | 2 | 04 |
| 1960 | 55 | 39 | 71 | 14 | 25 | 2 | 04 | 47 | 85 | 6 | 11 | 2 | 04 | 51 | 92 | 2 | 04 | 2 | 04 |
| 1961 | 46 | 31 | 67 | 10 | 22 | 5 | 11 | 34 | 74 | 4 | 09 | 8 | 17 | 34 | 74 | 4 | 08 | 8 | 17 |
| 1962 | 48 | 40 | 83 | 7 | 15 | 1 | 02 | 43 | 90 | 3 | 06 | 2 | 04 | 45 | 94 | 1 | 02 | 2 | 04 |
| 1963 | 53 | 35 | 66 | 14 | 26 | 4 | 08 | 44 | 83 | 4 | 08 | 5 | 09 | | | | | | |

Another aspect of Table 8 warrants discussion. As noted above, the number of escapes (now called AWOL) has increased from four in 1954-55 to 152 in 1963-64. This statistic refers to the number of times patients have left the hospital grounds without permission, not to the number of patients who have walked away from the grounds. Thus, one patient may be responsible for more than one of the escapes tabulated. Even considering this factor, however, the drastic increase indicates a more relaxed and permissive hospital administration, which in turn indicates a more accepting, relaxed, and permissive community. The hospital's desire to maintain a policy of open and free passage, a vital aspect of effective treatment programs, is highly dependent upon an accepting and permissive community, willing to understand and tolerate an increase in the number of patients who are AWOL.

## LENGTH OF FIRST HOSPITALIZATION AT HAWAII STATE HOSPITAL

In order to assess the efficacy of a hospital treatment program, it is appropriate to ask how long patients remain in the hospital. Although length of hospitalization by itself is not a valid criterion for evaluation of a treatment program, it does provide an initial basis in relation to other measures, e.g., proportion of readmissions, length of discharge, etc. In order to make any of these evaluations, it is necessary to create a cohort, i.e., a group of patients to be followed through time to determine what happens to them after they arrive at the hospital.

Table 9 shows the length of hospitalization of a cohort of patients admitted to Hawaii State Hospital for the first time during the months of January and July for the ten-year period.

The statistics on hospitalizations lasting three months or less do not show a consistent or significant change over the ten years. However, the statistics on patients remaining in the hospital six months or longer, presented in Table 9, do indicate that fewer patients remained in the hospital for periods of six months or longer in 1963-64 than was true ten years earlier.

In studying the history of the 478 patients admitted to Hawaii State Hospital for the first time during the ten-year period and included in this sample, it was found that only five were never discharged. Thus commitment to Hawaii State Hospital is not the end of the road.

## LENGTH OF FIRST DISCHARGE AFTER ADMISSION TO HAWAII STATE HOSPITAL

The previous paragraphs note that patients were remaining in the hospital in 1963-64 for shorter periods than was true ten years earlier. A question that follows from this observation is whether patients are less able to remain on discharge as a consequence of shorter periods of hospitalization.

Table 10 presents the statistics on the same patients examined in the previous section, that is, all of the patients admitted during January and July for the ten-year period and looks at the length of their first discharge from the hospital.

Table 10 indicates the number and the percentage of patients who were able to remain out of the hospital at least six months, one year, and two years. The total in the first column represents the number of those admitted during the specified periods who were placed on discharge.

Inspection of Table 10 does not show a con-

TABLE 10.—*Length of Discharge After First Admission—1954-63.*

| YEAR | TOTAL OF SAMPLE DISCHARGED (MINUS DEAD) | SIX MONTHS POST HOSPITALIZATION | | | | ONE YEAR POST HOSPITALIZATION | | | | TWO YEARS POST HOSPITALIZATION | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | TOTAL OUT | | TOTAL RETURNED | | TOTAL OUT | | TOTAL RETURNED | | TOTAL OUT | | TOTAL RETURNED | |
| | N | N | % | N | % | N | % | N | % | N | % | N | % |
| 1954 | 39 | 33 | 85 | 6 | 15 | 31 | 80 | 8 | 20 | 28 | 72 | 11 | 28 |
| 1955 | 39 | 35 | 90 | 4 | 10 | 32 | 82 | 7 | 18 | 25 | 64 | 14 | 36 |
| 1956 | 41 | 38 | 93 | 3 | 07 | 34 | 83 | 7 | 17 | 25 | 64 | 8 | 20 |
| 1957 | 40 | 26 | 65 | 14 | 25 | 24 | 60 | 16 | 40 | 21 | 53 | 19 | 47 |
| 1958 | 37 | 29 | 78 | 8 | 22 | 27 | 73 | 10 | 27 | 22 | 60 | 15 | 40 |
| 1959 | 40 | 34 | 85 | 6 | 15 | 30 | 75 | 10 | 25 | 23 | 58 | 17 | 42 |
| 1960 | 52 | 47 | 90 | 5 | 10 | 41 | 79 | 11 | 21 | 36 | 69 | 16 | 31 |
| 1961 | 36 | 25 | 70 | 11 | 30 | 22 | 62 | 14 | 38 | 18 | 50 | 18 | 50 |
| 1962 | 46 | 38 | 82 | 8 | 18 | 36 | 78 | 10 | 22 | 34 | 74 | 12 | 26 |
| 1963 | 46 | 35 | 76 | 11 | 24 | 32 | 70 | 14 | 30 | | | | |

sistently significant trend over the ten-year period. There is some suggestion, however, that although remaining in the hospital for shorter periods, patients were better able to maintain themselves on discharge during the last half of the ten-year period. If so, it is probable that multiple factors contribute to the patients' better ability to maintain themselves on discharge. Casual speculation would suggest the following: (1) use of tranquilizing drugs, (2) better treatment programs, (3) better placement planning, (4) a more tolerant community, and (5) shorter periods of hospitalization which allows less dependency to be developed. However, before any conclusive statement can be made, additional data would have to be collected and analyzed.

It would seem that length of hospitalization may not be directly related to ability to remain on discharge. However, our data do not provide definite conclusion on this point.

## SUMMARY AND CONCLUSIONS

The statistics of the Hawaii State Hospital over a ten-year period indicate that the hospital is undergoing significant change. Consistent with findings from the mainland and following a general trend throughout the world, the hospital is losing some of its negative aspects by becoming more treatment-oriented and less custodial in nature. Although an increasing number of patients are coming into the hospital, the resident population has dropped. In addition, more patients were coming into the hospital in 1963-64 on a voluntary basis and staying for periods of shorter duration than ten years earlier. It appears that even though patients remained in the hospital for shorter periods of time, the length of time they are able to remain out of the hospital has not been reduced; indeed, it has been lengthened somewhat.

The statistics concerning the sex, age, ethnic background, and diagnosis of patients coming into the hospital suggest some basic changes in the patient population. In addition, the possible implication of a sharp increase in the frequency with which patients are away from the hospital without leave (AWOL) are discussed.


## ACKNOWLEDGMENT

The author wishes to express his appreciation to Mrs. Glenna Albers, Hawaii State Hospital Auxiliary, and the Psychology Staff of the Hawaii State Hospital for their assistance with this study. ■



428 Kalaimoku St.



# *Buy Easter Seals!*

They support the National Society for Crippled Children and Adults.

*In 15 years, Hawaii's population has risen steadily and the annual first admissions to Hawaii State Hospital have fallen.*

# First Admissions to Hawaii State Hospital, 1950-1965

JOHN M. ROSENFELD, Ph.D.,* *Kaneohe*

• *The total annual first admissions to Hawaii State Hospital have declined over the past 15 years, from an average of 380 per year (1950-54) to 270 (1955-59) and 288 (1960-64). The total rise during the last two five-year periods is so far offset by the rising population that the ratio of admissions to 100,000 population dropped from 51.2 (1955-59) to 45 (1960-64); in 1965 it fell to 37.6 The author suggests that increased facilities for early diagnosis and early treatment are increasingly obviating the need for hospitalization.*

THIS ARTICLE reports the ratio of first admissions per 100,000 civilian population to Hawaii State Hospital for the years 1950-1965.

Table 1 presents the civilian population estimates for the State, the number of first admissions to the hospital, and the ratio of first admissions per 100,000 population. There is a definite downward trend for the 15-year period. From 1950 to 1957, particularly, the ratio drops considerably—from 90.1 to 48.5. From 1958 to 1965 the ratio varies from a high of 49.2 (1958) to a low of 37.6 (1965).

## WHY THE DROP?

The fact is clear that there has been a considerable drop in the first admission rate for the past 15 years. The explanation of this drop is not as clear, however. It is most likely due to the early detection of many psychiatric problems by extra-hospital psychiatric facilities. Such facilities, as they have become available to the general public, may well have prevented many people from entering the State Hospital by detecting their problems at earlier stages. Lending support to this contention, Bahn *et al.*[1] report that, for the United States as a whole, the increase in outpatient services has paralleled the decrease in the resident population of state mental hospitals. Although the present

TABLE 1.—*Ratio of First Admissions to Hawaii State Hospital per 100,000 Civilian Population, 1950-1965.*

| YEAR | POPULATION | FIRST ADMISSIONS | RATIO PER 100,000 POPULATION |
|---|---|---|---|
| 1950 | 472,780 | 426 | 90.1 |
| 1951 | 471,853 | 398 | 84.3 |
| 1952 | 462,494 | 394 | 85.2 |
| 1953 | 468,301 | 362 | 77.3 |
| 1954 | 474,391 | 313 | 66.0 |
| 1955 | 491,899 | 325 | 66.1 |
| 1956 | 512,200 | 278 | 54.3 |
| 1957 | 538,296 | 261 | 48.5 |
| 1958 | 560,448 | 276 | 49.2 |
| 1959 | 580,505 | 221 | 38.1 |
| 1960 | 595,024 | 252 | 42.4 |
| 1961 | 612,673 | 289 | 47.2 |
| 1962 | 635,888 | 307 | 48.3 |
| 1963 | 655,546 | 289 | 44.1 |
| 1964 | 674,951 | 292 | 43.3 |
| 1965 | 702,030 | 264 | 37.6 |

Source: Population estimates from Research, Planning, and Statistics Office, Hawaii Department of Health. First admission data from Statistical Reports, 1950-1964, and Psychiatric Inpatient Program Report, 1966, Hawaii Department of Health.

* Staff Psychologist, Hawaii State Hospital.
Received for publication March 11, 1966.

article deals only with new admissions to the State Hospital and not with the total resident population, it is apparent that a decrease in the number of first admissions leads to a lowering of the total hospital population.

This explanation can be treated as a hypothesis and put to a reasonable empirical test. One would expect at least the following findings if the hypothesis is correct: (1) There should have been an increase in the number of state and private outpatient facilities during the past 15 years. As a corollary of this, one would expect to find a steadily increasing case load in these clinics over the years. (2) There should have been an increase in the number of private practitioners dispensing psychiatric services over this time period. (3) There has been an increase in the counseling and guidance services available in the school system.

## ROLE OF DRUGS

A comment about the use of psychiatric drugs seems called for. All practitioners agree upon the value of such drugs in helping people recover from mental disorder and in stabilizing and keeping people from entering mental hospitals. However, the psychiatric "drug revolution" is usually dated as beginning about 1956-1957. It will be remembered from Table 1 that the first admission ratio drops most precipitously up to 1957. It appears, therefore, that the use of drugs cannot account for this drop in first admissions.

The role of drugs in the smaller post-1957 drop in first admissions is not clear. It would seem, however, that psychiatric drugs as used today contribute to keeping people out of mental hospitals. Using them, it is often possible to treat people as outpatients rather than as inpatients. If true, this fact should be reflected in the increasing case load of outpatient facilities which was hypothesized previously.

## CONCLUSIONS

If the hypothesis is indeed correct, there are some important conclusions to be drawn. First, the money spent by the State on outpatient psychiatric facilities is money well spent. Humanistically, it helps people to stay out of a mental hospital—a most desirable state of affairs. Economically, many of these people do not become wards of the State. Secondly, the private clinics and the private practitioners are contributing their part to the lowered first-admission rates found for the State. Third, counseling services in our schools may have become a focal point in the fight against mental disorder. The school is certainly an ideal spot for the early detection and prevention of mental problems.

## ACKNOWLEDGMENTS

The author is indebted to Dr. Howard E. Gudeman for his help in preparing this article.

## REFERENCE

1. Bahn, A. K., Rosen, B. M., McCarty, C. L., and Rippy, M. A.: Current services and trends in outpatient psychiatric clinics, 1963, Psychiat. Studies and Projects 3:7 (Oct.) 1965.

*The influence of ethnic background on gourmandise has some unexpected and intriguing angles, reported here.*

# Food Choice and Acculturation Among Some Ethnic Groups in Hawaii*

KAJORN LEKHAKUL HOWARD, M.S., *Honolulu*

• *Chinese cuisine has made the largest total contribution to the regular eating habits of other ethnic groups, though only three Chinese dishes (shrimp with pineapple, shrimp with broccoli, and sweet and sour pork) made the list of the ten most popular dishes, while six Japanese items made the grade (teriyaki, hekka, shrimp tempura, sashimi, sukiyaki, and kamaboko). The tenth was Hawaiian: laulau. Least receptive to frequent use of other races' foods are the American Caucasians; Chinese are almost as conservative, except that they have adopted Hawaiian foods quite freely. Hawaiians have been highly receptive, particularly to rice (which they favor above poi) and to cooking styles of other groups.*

HAWAII offers an excellent opportunity to study changes in food choice resulting from culture contact. As the various ethnic groups migrated to the islands, each brought with it a culinary tradition distinct from the others, including that of the indigenous Hawaiians. Several research papers have described aspects of these traditions, [1, 2, 3] but little work has been done on the degree of persistence and change in the diets of the component groups and the extent to which foods have come to be shared between them. This paper reports the results of an exploratory study involving food choice among members of six ethnic traditions—Chinese, Filipino, Hawaiian, Japanese, Korean, and Caucasian-Americans. Although the samples used are inadequate for drawing any conclusive generalizations, the results are nevertheless suggestive. It is hoped that they will stimulate further research in this area.

## METHODS

The first step in preparing the questionnaires was to ascertain the names, cooking style, and food content of commonly eaten dishes associated with the ethnic groups included in the study. These were then organized by major food groups, such as beef dishes, pork, eggs, etc. Each dish was listed by name with an accompanying description and a letter in parentheses indicating national origin. For example:

> Chapchey (K)
> Mixture of vegetables and meat cooked in sesame oil and shoyu

The (K) indicates that the dish is of Korean origin.

A large number of foods were also listed, such as fruits and vegetables, that were not specifically associated with any ethnic group. No attempt was made to specify characteristically "American" dishes because of difficulties in identifying them and the disagreements as to which ones were characteristic. Out of a total of 290 food items listed, 17 were Chinese dishes, 19 were Filipino, 14 were Hawaiian, 10 were Korean, and 29 were Japanese. The remainder were general items such as specific fruits and vegetables, bread, milk, etc.

Alongside each name were five frequency categories: daily, frequently, occasionally, rarely, and never. Subjects were instructed to check the category which best described the frequency with which he or she ate the food item or dish named. In order to facilitate standardization of responses,

* Published with the approval of the Director of the Hawaii Agricultural Experiment Station as Technical Paper No. 775.
† Department of Home Economics, Division of Nutrition, University of Hawaii.
Received for publication January 23, 1966.

TABLE 1.—*Food Crossovers by Ethnic Group.*

| | ETHNIC DISHES | | | | | |
|---|---|---|---|---|---|---|
| | CHINESE | FILIPINO | HAWAIIAN | JAPANESE | KOREAN | AVERAGE MEAN |
| Chinese | .... | 1.3 | 1.9 | 1.7 | 1.3 | 1.5 |
| Filipino | 1.9 | .... | 1.3 | 1.6 | 1.5 | 1.6 |
| Hawaiian | 2.2 | 1.3 | .... | 1.6 | 1.6 | 1.7 |
| Japanese | 1.9 | 1.4 | 1.7 | .... | 1.6 | 1.7 |
| Korean | 1.9 | 1.3 | 1.7 | 1.8 | .... | 1.7 |
| Average Mean | 2.0 | 1.3 | 1.7 | 1.7 | 1.5 | |

the following definitions were supplied on every questionnaire:

*Daily:* eaten every day or nearly every day
*Frequently:* eaten on an average of once a week or more
*Occasionally:* a regular item of diet but eaten at long intervals or only seasonally
*Rarely:* infrequently eaten and not part of ordinary diet

Once the questionnaire was completed, copies were distributed to a nonrandom sample of 120 adults, 20 from each ethnic group. National origin was left to self-identification, each person specifying the group with which he associated himself. The subjects ranged between 20 and 40 years of age and were of both sexes. All were in professional or allied occupations. They were purposely selected from this socio-economic stratum for several reasons, including their ability to understand the questionnaire, ready accessibility, and sufficient income to be able to make choices. It was also felt that they would be the least conservative members of their groups and would therefore best represent the maximum degrees to which acculturation had occurred.

In order to tabulate the data, numerical scores were assigned to the frequency categories as follows:

| | |
|---|---|
| Daily | 5 |
| Frequently | 4 |
| Occasionally | 3 |
| Rarely | 2 |
| Never | 1 |

Tabulations were then made for each food item by ethnic group of subjects, and a mean score computed. Those dishes that had been specifically identified with a given nationality were grouped together and an average mean statistically computed. This resulted in a matrix table of mean scores indicating the degree to which the members of each ethnic group ate dishes associated with the other groups. The results are presented in Table 1, which may be interpreted as follows:

The rows designate ethnic group and the columns the national origins of dishes. The figure in each cell represents the mean frequency with which the members of a group eat the dishes of another group. For example, the figure 1.9 in the second cell from the top of the left-hand column represents the extent to which Filipinos eat Chinese food. The average means in the right-hand column are indices of the degree to which each group of subjects eats food associated with the other ethnic groups. These might be called "receiver indices" in that they indicate the degree to which each group has been receptive to alien dishes. The average means at the bottom of the table are indices of the popularity of dishes associated with each nationality. They might be termed "donor indices" in that they indicate the degree to which each group has contributed to the diets of the other groups. Table 2 compares the donor and receiver indices for each group.

TABLE 2.—*Comparison of Ethnic Groups by Popularity (Donor Index) and Receptivity (Receiver Index).*

| | DONOR INDEX | RECEIVER INDEX |
|---|---|---|
| Chinese | 2.0 | 1.5 |
| Filipino | 1.3 | 1.6 |
| Hawaiian | 1.7 | 1.7 |
| Japanese | 1.7 | 1.7 |
| Korean | 1.5 | 1.7 |

The Caucasian-American group is not represented in Table 1 because of difficulties in identifying dishes exclusively with them. As a receiver group, they had an average mean of 1.3.

## RESULTS

The figures in Table 1 suggest that the Japanese, Korean, and Hawaiian groups have been most responsive to the food of others. They are followed by the Filipinos and Chinese. Although not listed in the table, it is interesting to note that the Caucasian-Americans have the lowest receiver index. Of the ethnic dishes, Chinese cuisine is clearly the most popular, followed by Japanese, Hawaiian, Korean, and Filipino in descending order. This would seem to indicate that although the Chinese themselves are rather conservative in food choice, their food culture has diffused most, while the Japanese and Hawaiians have been both donors and receivers. The Koreans and Filipinos, on the other hand, have absorbed alien dishes to a greater extent than others have adopted their dishes. These results are clearly tentative, for the differences are not great. However, the findings

TABLE 3.—*Consumption of Food Types by Ethnic Group.*

| | CAUCASIAN-AMERICAN | CHINESE | FILIPINO | HAWAIIAN | KOREAN | JAPANESE | AVERAGE MEAN |
|---|---|---|---|---|---|---|---|
| Beef | 2.6 | 2.6 | 2.3 | 2.2 | 2.8 | 2.6 | 2.5 |
| Pork | 1.7 | 2.5 | 2.2 | 2.2 | 2.1 | 2.3 | 2.2 |
| Poultry | 2.3 | 2.6 | 2.4 | 2.2 | 2.3 | 2.4 | 2.2 |
| Seafood | 2.0 | 2.3 | 2.4 | 2.2 | 2.0 | 2.1 | 2.3 |
| Eggs | 2.3 | 2.8 | 2.5 | 2.5 | 2.5 | 2.7 | 2.5 |
| Beans | 1.9 | 2.2 | 2.1 | 1.8 | 2.3 | 2.6 | 2.2 |
| Bread (brown) | 4.3 | 2.7 | 2.0 | 3.2 | 3.0 | 3.2 | 3.1 |
| Bread (white) | 3.5 | 3.8 | 4.2 | 4.3 | 4.6 | 4.6 | 4.2 |
| Rice | 3.5 | 4.1 | 5.0 | 4.3 | 4.8 | 5.0 | 4.5 |
| Poi | 2.0 | 3.4 | 1.7 | 4.2 | 3.1 | 3.0 | 2.9 |
| Milk | 4.5 | 4.9 | 3.8 | 4.8 | 4.9 | 4.1 | 4.5 |

are not unexpected and may be treated as hypotheses to be tested by more exacting research.

Table 3 also shows some interesting findings. For example, the Caucasian-Americans use brown bread with a much higher frequency than the other groups, all of whom favor white bread. It might be postulated that the choice of white bread among the Oriental groups is related to the value they place upon white rice. Also interesting is the degree to which poi has been adopted as a food by other groups, and particularly the Chinese, Koreans, and Japanese.

The popularity of specific fruits and vegetables is shown in Table 4. The food items are divided into three groups: those with an average frequency of 3.0 for every group and which therefore might be termed "universal" foods, those with an average frequency of 3.0 for some groups but not for others, and those with an average frequency of less than 3.0 for every group. The table shows certain items to be favored by only one group, such as sweet potato leaves and tops, taro roots and leaves, guava, etc., while other items are more generally approved or disapproved.

Different cooking methods appear to be favored by the various groups as indicated in Table 5. The Caucasian-Americans and Chinese both favor oven roasting, the Filipinos favor frying, and the Hawaiians stewing. Among the Koreans, oven roasting and barbecuing were equally popular. On the whole, oven roasting and stewing are the most frequently employed methods of cooking.

The most popular ethnic dishes are dominated by the Japanese and Chinese as can be seen in Table 6. Of the top ten, six are Japanese, three are Chinese, and one is Hawaiian.

TABLE 4.—*Popularity of Specific Fruits and Vegetables Among Hawaii's Ethics Groups.*

1. Fruits and vegetables with an average frequency of 3.0 or more for every group:

| | |
|---|---|
| Bananas | Lettuce |
| Apples | Cabbage |
| Papaya | Tomatoes |
| Oranges | Carrots |
| Pineapple | Cucumber |
| | Onions |
| | Watereress |
| | Celery |
| | Corn |

2. Fruits and vegetables with an average frequency of 3.0 or more for some groups, but not for others:

| | |
|---|---|
| Avocado (H,C,K)* | Potatoes (A,J,C,K,H) |
| Watermelon (C,K) | Spinach (A,C,H,K,J) |
| Lime (C,H) | Ginger (F,C,J,K) |
| Mountain apples (C,J) | Bamboo shoots (J,C,F,K) |
| Lemon (J,C) | Broccoli (F,C,A,K) |
| Guava (F) | Cauliflower (F,C,A,J) |
| | Eggplant (F,J,K) |
| | Squash (J,C) |
| | Bitter melon (F,C) |
| | Yams (C,J) |
| | Lotus root (C,J) |
| | Turnips (J) |
| | Taro leaves (H) |
| | Taro roots (H) |
| | Cowpeas (F) |
| | Sweet-potato leaves (F) |
| | Sweet-potato tops (F) |

3. Fruits and vegetables with an average frequency below 3.0 for all groups:

| | |
|---|---|
| Strawberries | Tapioca |
| Passion fruit | Swamp cabbage |
| Figs | Arrowroot |
| Cherries | Ti root |

* Letters in parentheses indicate groups with a frequency of 3.0 or more. Designations are (A) Caucasian-American, (C) Chinese, (F) Filipino, (H) Hawaiian, (J) Japanese, and (K) Korean.

TABLE 5.—*Frequency of Cooking Methods Employed by Ethnic Groups.*

| METHOD OF COOKING | CAUCASIAN-AMERICAN | CHINESE | FILIPINO | HAWAIIAN | KOREAN | JAPANESE | AVERAGE MEAN |
|---|---|---|---|---|---|---|---|
| Roasting (oven) | 3.2 | 3.4 | 3.2 | 2.7 | 3.2 | 2.9 | 3.1 |
| Stewing | 2.8 | 3.1 | 2.8 | 3.3 | 3.0 | 3.4 | 3.1 |
| Barbecuing | 2.7 | 2.6 | 3.0 | 2.7 | 3.2 | 3.7 | 3.0 |
| Frying | 2.1 | 2.7 | 3.4 | 2.2 | 3.0 | 3.2 | 2.8 |
| Broiling | 2.7 | 2.7 | 3.0 | 2.2 | 2.5 | 2.7 | 2.6 |
| Roasting (pot) | 2.2 | 3.0 | 2.2 | 2.5 | 3.0 | 2.7 | 2.6 |

TABLE 6.—*Ten Most Popular Ethnic Dishes.*

| | AVERAGE MEAN* |
|---|---|
| 1. Teriyaki (J) (beef soaked in shoyu) | 2.7 |
| 2. Hekka (J) (chicken long rice) | 2.7 |
| 3. Poh Loh Ha (C) (pineapple and shrimp) | 2.6 |
| 4. Sweet and Sour Pork (C) | 2.5 |
| 5. Shrimp Tempura (J) (fried shrimp with batter) | 2.5 |
| 6. Sashimi (J) (raw fish) | 2.5 |
| 7. Laulau (H) (pork and taro leaves) | 2.4 |
| 8. Sukiyaki (J) (beef or pork or chicken, with vegetables) | 2.4 |
| 9. Kamaboko (J) (fishcake) | 2.3 |
| 10. Ha Chok Kai Lanchoy (C) (shrimp with broccoli) | 2.0 |

* Average means do not include scores of the group identified with the dish. For example, the average mean for teriyaki includes scores for all groups except Japanese, poh loh ha for all groups except Chinese, etc. The figures, therefore, represent the degree to which the dishes have been adopted by other groups.

In general the results suggest the following about each ethnic group:

*Chinese:* The Chinese are rather conservative when it comes to food choice, confining themselves relatively closely to their own foods. They have taken on Hawaiian foods more than that of any other group, with poi in particular being popular with them. As for fruits and vegetables, the Chinese have adopted a wide range of choice. The implications are that they have been receptive to new food items but tend to prepare them in their own traditional style rather than adopting the styles of others.

*Filipinos:* Basically the Filipinos also appear to be conservative, having been most receptive to Japanese food. They have been least receptive to such foods as poi, milk, brown bread, potatoes, and spinach. Their conservatism therefore also seems to include specific food items, unlike the Chinese. In cooking style they retain frying as the dominant mode to a stronger degree than the other Asian groups.

*Hawaiians:* The data indicate that the Hawaiians have been a receptive group, particularly when it is realized that their diet was originally the most distinctive traditionally. They have been most influenced by Chinese food, and have adopted rice as a staple. The score for rice even surpasses that of poi. Among specific fruits and vegetables, however, the Hawaiians have shown a reluctance to adopt distinctively Oriental items such as ginger and bamboo shoots. They have retained an interest in taro roots and leaves. Among cooking styles, stewing ranks highest for them, a method which deviates from their traditional technique of cooking in earthen ovens. Thus the Hawaiians have responded in a somewhat reverse fashion from the Chinese: they have adopted somewhat fewer specific foods but have readily altered their cooking styles.

*Japanese:* The Japanese have been almost equally receptive to dishes from each of the other ethnic groups, most so for Korean. Like the Chinese, they have adopted a wide range of fruits and vegetables, although they seem to be less committed to traditional cooking methods.

*Koreans:* The figures indicate that the Koreans have also been receptive, particularly to Chinese and Japanese foods. It seems probable, however, that the influence of these two cultures was felt in Korea through Chinese cultural and Japanese political dominance. The Koreans have, like the Japanese and Chinese, adopted a wide range of fruits and vegetables.

*Caucasian-Americans:* One of the surprising findings of this study is the extreme conservatism of the Caucasian-American group. Professionals of this background often make a point of eating alien foods, but apparently this is confined to experiments, either at home or in restaurants; evidently they do not often make these dishes parts of their diet.

## CONCLUSION

Choice behavior is an excellent area for studying the effects of culture contact on specific ethnic groups. With contact come new opportunities and a multiplication of choices in a variety of behavioral areas. From studying the choices actually made under such circumstances, we stand to learn a great deal about the processes of culture change. Food choice in acculturation contexts is doubly significant. Not only does it provide an index of receptivity to other cultures, but it provides a key to changing health and welfare patterns. The study reported in this paper is in part an exploratory effort to see if such research is feasible in Hawaii. It is the author's opinion that the results are encouraging enough to warrant much more research on this topic.

## ACKNOWLEDGMENTS

I would like to thank Dr. Bluebell Standal of the Department of Home Economics, Division of Nutrition, at the University of Hawaii for her encouragement and advice in carrying out this research, which was done under her guidance. Acknowledgments are also due to my anthropologist husband, Dr. Alan Howard, who edited the paper and made several useful suggestions concerning the cultural implications of the data.

## REFERENCES

1. Miller, Carey D.: Japanese foods commonly used in Hawaii, Hawaii Agr. Expt. Sta. Bull. 68 (1933), 41 pp. illus.
2. Miller, Carey D., Louis, Lucille, and Yanazawa, Kisako: Vitamin values of foods in Hawaii, Hawaii Agr. Expt. Sta. Bull. 6 (1947), 56 pp.
3. Miller, Carey D., Louis, Lucille, and Yanazawa, Kisako: Foods used by Filipinos in Hawaii, Hawaii Agr. Expt. Sta. Bull. 98 (1946), 80 pp. illus.

# Report

*Detection and prevention are the keynote topics in this report of a cancer meeting.*

# Special Report: American Cancer Society, 1966 Scientific Session

## San Francisco, May 18, 1966

NORMAN R. SLOAN, M.D., *Honolulu*

THE MEETING was held in the St. Francis Hotel. The arrangement was poor in that the morning session, from 9:00 A.M. to 1:00 P.M., was conducted without a break; this was also true of the afternoon session from 2:00 P.M. to 4:30 P.M. Speakers were good for the most part, but there was very little in the presentations which could be considered new, or, so far as I could see, of special value. It was largely repetition of things which we had heard many times.

When new ideas were presented, we heard things like: "This has some promise, but it is not yet established. It is still in the research stage." "This is not practical for screening, because of need for frequent repetition, expense, and low return." "At present, the old ways are still best."

The meeting centered on cancer of six sites: uterus, colon and rectum, lung, breast, oral cavity, and skin. Dr. Lewis W. Guiss, of U.S.C., stated that these six sites account for 60 per cent of all cancers; that they are *accessible* and *treatable,* and some are *preventable;* and that the ACS is devoted to "closing the gap" between known preventives and their use. (But there is still a long way to go.)

Received for publication July 27, 1966.

### UTERINE CANCER

This was chaired by our Dr. Irvin L. Tilden, who briefly reviewed the history of the Papanicolaou smear method of screening.

*The Present Status of Cytology in Uterine Cancer.* Leopold G. Koss, M.D., Memorial Hospital, New York.

Cancer of the cervix parallels that of other mucous membranes. It does not strike, it creeps on slowly. Why do we not fully implement our knowledge of this cancer? It is a public health problem; there are many practical problems in getting regular examinations, both among doctors and patients; one of the most important is the mental attitude of many women, who resist examination.

Cancer is a public health problem more important, statistically, than phenylketonuria, syphilis, or tuberculosis.

The cervical smear should be made a mandatory procedure in parous women over twenty, or even younger; at the least, it should be required in pregnant patients. Pregnancy is not a contraindication. (The health code of New York City requires "complete examination" of antepartum patients, but it does not specify the Papanicolaou exam.

Self-administered intravaginal devices are still being evaluated. The "cyto-pipette" *may* be of value. (It takes a long time; we were studying a tampon method ten years ago.)

The great problem is the effort to persuade practicing physicians to do smears on the apparently normal cervix. How often must we tell them?

There is a technique (no details were offered) of using a fluorescent orange dye, which can be used by "untrained personnel" in the physician's office as a *pre*screening method. It is *not* a means of diagnosis.

There are not enough cytotechnologists. At least five minutes should be given to a smear before pronouncing it negative, sometimes as much as 30 minutes; and a technician should not work more than five to six hours a day.

On patients aged 45 or over, a vaginal pool specimen should be examined as well as a cervical scraping; in this way cancer of the endometrium, tubes, or ovaries is sometimes detected. (This is generally accepted.)

"Cervical dysplasia" is a "wastebasket" term which includes many precancerous lesions.

The "cytoanalyzer"—an automated device for screening—has been tried for many years, but generally discarded because of the difficulty of getting smears only one cell thick. Another approach is being tried by IBM; cells are checked in a fluid column; comparison of ultra-violet and regular counts gives an idea of the relative amount of nuclear material.

"The conquest of a major form of human cancer is clearly within our reach."

*The Optimum Status of a Patient with a Positive Cervical Cytology Report.* Tommy N. Evans, M.D., Wayne State University.

Good liaison is needed between clinician and pathologist.

Competing classifications are confusing.

"Suspicious" lesions *demand* biopsy.

There are high-risk groups; a prison population in Detroit gave four times the expected return.

The Schiller test has been greatly overrated, especially in postmenopausal women; it is worthless in the presence of scars.

Punch biopsy of several sites, in the office, is recommended; if benign, do conization and curettage.

Try saline lavage, aspiration, and millipore filtration.

The optimum treatment for *invasive* cancer is *radiation.*

In preinvasive carcinoma, conization permits further observation if babies are wanted.

## COLON AND RECTAL CANCER

Chairman, John G. Walsh, Sacramento.

Less than 20 per cent of physicians use the scope for diagnosis.

*Current Procedures in the Detection and Diagnosis of Colon and Rectal Cancer.* H. Marvin Pollard, M.D., University of Michigan.

In a group of faculty members at Ann Arbor, a "significant finding" occurred in 10 per cent of those proctoscoped.

"Thermography" is a new technic in which any necrotic or inflamed tissue will produce a difference in reading. No use as yet.

Radioactive $P^{32}$ is good for detection of cancer of stomach and esophagus—he did not say how.

Intraarterial hydrogen peroxide may have value.

Study is being given to intraarterial injection of radio-opaque dye with 10x enlargement of picture —called "microangiography."

Efforts to develop useful techniques for cytologic study of colon washings are still under way. Preparation is vital; one method is use of a millipore filter. Also try differential centrifugation; 1.040 is the critical specific gravity. In any case the method should be reserved for high lesions not reached by proctoscopy or readily diagnosed by x-ray.

Use of a silicone foam colonic injection, which forms a mold of the colon, is being evaluated.

Comments on proctoscopy:

Preparation: magnesium citrate plus two Travad enemas.

"The proctoscopist can be graded by the distance he gets up." Aim for 25 cm.

The Ritter table is "the most important feature of the examination."

Try not to use air; it spoils a subsequent barium enema.

Types of scope: Buie is "the workhorse." Welch-Allyn has a "fiber-optic" (flexible) instrument which is good, but does not permit biopsy; it does include water and suction, and the tip is controllable. There is a disposable unit, but the caliber is rather large.

Teaching. A three-hour course was offered to 1,500 physicians; 140 said "yes," 112 came. Included 50 minutes of a TV tape, slides of lesions, two patients for each doctor; then they worked on each other (on a voluntary basis!).

*Modern Treatment of Colon and Rectal Cancer.* Warren H. Cole, M.D., University of Illinois.

In 40 years, operative mortality decreased from 40 per cent to two to four per cent. Five-year survival is also much better.

Emphasizes preoperative nutrition, anesthesia, and use of silk in suturing outside layers.

There is still too long a delay before operating. Ten years ago the average was 11.3 months; three years ago it was only down to 10.3 months! It should not be more than four weeks. Why? There is no pain in early stages, only mild distress and anorexia.

Methods of spread are varied: local involvement; blood; lymph; implant (spontaneous and iatrogenic). In most cases it will not spread more than one or two cm distally; the spread is proximal. Vascular spread is "the most untreatable."

What do we do about polyps? Transformation to invasive cancer is rare. Most clinicians think they should be removed; but if the patient has only four or five years' life expectancy, let him go, unless the radiologist indicates probable malignancy.

There is disagreement on the extent of resection required. Dr. Cole's principle: right colon—out. Transverse colon—out, mobilize flexures. Left colon—mobilize splenic flexure, if high.

Palliative resection will at least save blood and plasma loss.

In operating for cancer of right colon, most surgeons have been wrong. Start in upper quadrant, cut off blood supply first. Care for lumen and vascular trunks early. Keep wound and tumor covered. Change gloves often. Excise the crushed end. Use silk sutures.

Familial multiple polyposis calls for excision; there is usually cancer by age 40.

*The Radiological Detection of Cancer and Polyps of the Colon and Rectum.* Wendell G. Scott, M.D., Washington University (St. Louis).

The radiologist can usually detect polyps, but cannot tell whether they contain cancer cells.

One fourth of patients diagnosed are inoperable; another 25 per cent show metastases at operation.

We need sigmoidoscopy plus x-ray; and both may miss. Ten per cent of polyps are above the scope level. About two-thirds of polyps are silent. The larger the polyp, the greater the chance of malignancy.

Do not overlook children; they may have "retention polyps" which are not malignant, but sometimes slough.

All loops of bowel must be x-rayed in at least two views at right angles.

Preparation: clear soup and tea for supper; no breakfast. Castor oil; two enemas at bedtime; enemas till clear in morning.

Start barium with patient in left oblique, turn to right oblique, then prone; tilt upright.

## LUNG CANCER

Chairman, Sol R. Baker, M.D., U.C.L.A.

There are 45-50,000 deaths each year.

*The Control of Cigarette Smoking in the U.S.A.* The Honorable Maurine B. Neuberger, U.S. Senator for Oregon.

This was a fascinating interlude, with some interesting factual items.

Great Britain has banned cigarette advertising on TV. In 1965, sales were down two per cent.

"There are no short cuts; it must come from within you."

"On the side of the Senate on which I sit, there are only five cigarette smokers."

The U.S. Treasury gets two billion dollars per year from tobacco taxes.

A letter from a young correspondent asked, "Why is your State's capital named for a cigarette?"

*The Early Diagnosis of Lung Cancer.* Thomas Carlile, M.D., The Mason Clinic, Seattle.

Do available tests have the potential of solving the diagnostic problem?

Chest x-ray has value, but limitations. There is lack of specificity. Much study is being done. Retrospective study is "a very humbling experience."

A prospective study of over 6,000 men, checked symptoms and x-ray every six months. Ninety new cases of lung cancer developed. *All were smokers.* The sooner a lesion was found after a normal lung x-ray, the worse was the prognosis. Some symptoms occurred in 80 per cent before the tumor could be seen. The commonest were dyspnea and cough. But both coughers and noncoughers developed cancer.

Over half of the cancer patients had other pulmonary pathology. So we have a high-risk group: smoking males, 45 and over, coughing, with some small lung abnormality. But routine six-month x-rays probably would not be feasible, economical, or justifiable by results.

Sputum is hard to get; aerosol induction is not practical; cytology needs special ability, and "slows down the technician."

Bronchoscopy also is hardly practical. Melemid advises it every four weeks in doubtful cases! (or where sputum is positive, x-ray negative).

"The ideal screening procedure has not been found."

The patient's chances depend more on the biological nature of the cancer than on whether it is found early.

Chairman, John M. Dennis, M.D., University of Maryland.

We know much about cancer, but not enough.

One breast cancer patient survived for 43 years!

*Advances in the Early Diagnosis of Breast Cancer.* Thomas W. Botsford, M.D., Harvard; in absentia, read by Dr. Dennis.

Breast cancer is 23 per cent of cancer in women; 10.7 per cent of all cancer. One woman in 20 will have it. In 95 per cent of cases, the patient discovers the lump.

Diagnostic trials:

Radioisotopes ($P^{32}$, $Hg^{197}$) are of no use.

Ultrasound; now in research stage.

Thermography, a true heat photo, showing localized heat over inflamed and malignant tissue, gives too many false positives, but shows some promise. It has been suggested that heat grades with degree of malignancy.

Transillumination is valuable in cysts, but will not tell benign from malignant; its use is limited.

Cytology. Tumor cells in discharge are significant; negatives are of no value. It is no substitute for biopsy.

Breast Self Examination. This is still good—"for those who can and will do it."

Mammography is "here to stay." Negatives do not rule out biopsy of suspected lesions. In biopsies from lesions detected by mammography, 85 per cent had no involved nodes. Use it on special cases: cancer in other breast, family history, large breasts, etc. Include history and physical examination.

At present, the old ways are still best. The triad of patient, physician, and surgeon must not be broken.

*The Breast Cancer Treatment Controversy.* Robert C. Hickey, M.D., University of Wisconsin.

Breast cancer begins as a local event, progresses unrelentingly at variable rates. She never "outlives the stigma of the disease," but those treated live longer than those not treated.

In records of the Middlesex Hospital from 1792, 253 patients without treatment lived a median of 2.7 years; 20 per cent lived five years.

Gave a historical summary of various surgical treatments, Halsted, Willy Meyer, etc.

Questions on which there is controversy—no answers:

Internal mammary node excision
Radical vs. simple mastectomy
Radiation
Ovariectomy in premenopausal patients
Drug therapy



Chairman, B. L. Aronoff, M.D., University of Texas.

39-40 per cent of patients live five years.

*Oral Lesions of Neoplastic Significance and Oral Cancer.* Sol Silverman, Jr., D.D.S., University of California School of Dentistry, San Francisco.

Discussed epidemiology, control, premalignant lesions, and early detection.

They are about five per cent of all cancers. Male:female, 3:1. Average age, 60; 91 per cent squamous carcinoma. Accounts for 2½ per cent of cancer deaths, and the ratio is increasing.

Snuff produces epithelial hyperplasia, not cancer, as far as can be told with certainty.

Pipes produce keratosis ("smoker's palate"), leukoplakia, and cancer.

Cigarettes produce a grayish hyperplasia.

The Plummer-Vinson syndrome is related to atrophic mucous membranes, to mouth carcinoma, to alcohol.

Syphilis produces "cobblestone tongue," also related to cancer.

Denture irritation produces benign changes; also carcinomas.

Palatal capillary hyperplasia is not malignant.

Erythroplasia may become malignant.

Leukoplakia is definitely premalignant.

"Speckled leukoplakia" is malignant in more than 60 per cent of cases.

"White sponge nevus" is benign.

Lichen planus in mouth rarely if ever becomes malignant.

*But:* many benign changes in the mouth are hard to differentiate from premalignant ones; many early malignant ones look benign. Cytology may be a useful adjunct in diagnosis.

*Management of Oropharyngeal Cancer.* Arthur G. James, M.D., Ohio State University.

Diagnosis: physical examination, inspection, palpation.

Biopsy: bleeding controlled by pressure or silver nitrate stick.

Treatment Factors:

Histology: cell type, degree of differentiation
Location (over cartilage or bone?)
Age of patient
Previous treatment
Extent of involvement
General medical condition

Radiation and surgery are about equally effective.

General results of surgery are good. Lip, 70 per cent; other areas, 30-35 per cent.

SKIN CANCER

Chairman, Glenn H. Leak, M.D., State University of New York at Buffalo.

There are 5,000 deaths a year, many of them preventable.

*Early Recognition and Diagnosis of Skin Cancer.* Herbert L. Traenkle, M.D., State University of New York at Buffalo.

Some malignant and premalignant lesions:

Solar keratosis—most common premalignant lesion.

Cutaneous horn—sometimes malignant at base.

Other keratoses: arsenical (especially hard to treat on palms and soles); seborrheic (benign).

Radiation changes. Cancer may occur, and recur; easily removed, they should be followed for life.

Scars, occasionally premalignant.

Truly malignant lesions. Some less commonly detected:

Bowen's disease, an intraepithelial squamous carcinoma.

"Psoriasiform" or "eczematoid" carcinoma. Multiple superficial lesions, resembling eczema patches.

Pigmented—not true melanoma.

"Basal cell nevus syndrome." Rare, may become invasive. May develop before puberty, invade afterward. Most common on face; multiple.

Other benign lesions:

Multiple epithelioma adenoides cysticum. Looks malignant, but is not.

Keratoacanthoma. Rapid growth, destructive by size, but benign.

Ulcer in x-ray scar.

*The Treatment of Skin Cancer.* Richard H. Jesse, M.D., University of Texas.

First line of attack: early diagnosis.

Second line: early and adequate treatment.

To whom should one refer the patient? Ideal is a skin clinic, combining dermatology, radiology, and surgery.

Principles of treatment:

- Eradication of precancerous lesions
- Complete removal or destruction
- Best cosmetic result possible under the circumstances
- Least inconvenience, loss of time, and expense
- Availability of trained personnel and equipment

Modalities:

- Coagulating current after curettage. Best use is in lesions less than 1 cm. Too easy, so used by too many.
- Excision
- Irradiation as last resort for unmanageable cases

Skin Clinic program:

- Biopsy of all suspicious lesions
- Determine method to be used
- Use one modality at a time
- Treat with sufficient vigor to be curative

Considerations for selecting treatment method:

- Histologic type
- Location
- Size
- Previous treatment
- Age, condition, and occupation of patient

SPECIAL ADDRESS

*Premises and Prospects in Cancer Research.* Paul Weiss, Ph.D., University of Texas.

For the most part this was over my head, and I had to leave during part of it. A few points which I noted:

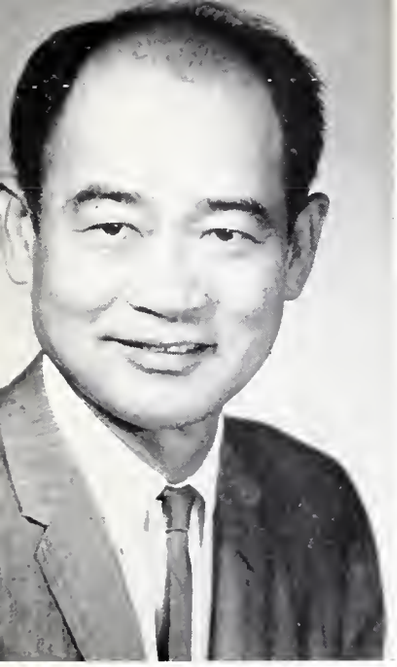
"The monopolistic hope has been shattered."

"Cancer is not a de-differentiation." (What does that mean?)

Differentiation comes about by innumerable steps, which may be transmitted to all cell progeny.

Trauma causes healing; causes more cell generation; causes greater possibility for tumor generation.

2722 Ferdinand Ave.





# *The President's Page*

The eleventh annual meeting of the Hawaii Medical Association will be held in Honolulu May 17-21. The over-all theme will be Genetics and Heredity in Today's Practice. Renowned authorities in such matters as congenital deformities and retardation will be present to lecture to our physicians.

It will be a monumental meeting and the subject matter is one that will attract wide attention among the laity as well as among professionals.

The certain success of that meeting will be largely attributable to a man who will not attend, Dr. Robert P. C. Ho, a colleague who should have been barely half way through his life when he was removed suddenly from his family, his friends, his church, and from his manifold responsibilities.

Dr. Ho died suddenly while he was making ready a superlative scientific program for the annual meeting, a program planned to outshine all previous programs. It would have been—it will be—his third splendid achievement in the field. Success of the last two scientific programs was due to the careful work of the committee he headed and inspired by his own unremitting search for excellence. Success of the next session is already assured because the basic work has been done by him. Little remains to be added to the structure of excellence that he built.

Dr. Ho achieved much in the field of medical education. He helped with the teaching of young doctors, turning his organizational ability to the improvement of hospital teaching programs. All of the state and county committees upon which he served bear his mark. He never was too busy to assume new tasks which, when completed, were well done. He not only worked tirelessly himself, but he had the inborn ability to inspire accomplishment by others. And his capacity to bring together the minds of those who labored and those who criticized that labor approached genius.

Doctors ideally are scientists, confidantes, counsellors, friends, and students in perpetuity. Dr. Ho met that ideal. In an ancient profession that still is met constantly with new challenges he met those challenges to the fullest.

It was Galen, more than two millennia ago, who said that "He cures most in whom most are confident." Dr. Ho had that confidence—of the profession and of his patients.

To his family, to which he was devoted despite the exhausting demands of his profession, goes our inadequate sympathy.

The annual meeting in May will be his memorial. Physicians attending will take part in a scientific program he guided to completion in their behalf.

Attendance will be their tribute to him.

Theodore Tomita, M.D.

HAWAII MEDICAL JOURNAL

# Editorials

## *Aloha Oiaio,* Leo Bernstein!

Leo Bernstein came to Hawaii from his native Boston a quarter of a century ago on an assignment for the U.S. Public Health Service. His wartime assignment as public health officer on Kauai in 1942, and on Hawaii in 1943, decided him to remain in Hawaii after his tour of duty with the USPHS ended; he joined the Territorial Health Department in 1946 as County Health Officer on the Island of Hawaii. Big Island health officers ever since have been hard put to maintain the record he established. In 1950 he was elected President of the Hawaii County Medical Society.

In 1951 he was promoted to Director of the Division of Hospitals and Medical Care, and two years later became Deputy Director of the entire Health Department. Nine years later, when Dr. Richard K. C. Lee left to head the new School of Public Health at the University of Hawaii, Dr. Bernstein moved into the top position, which he has held for the past four and a half years.

Dr. Bernstein's solid background in public health (he holds a master's degree in public health from Harvard) is matched by active participation in collateral activities during his tenure here. He has served on the Boards of Directors of the Hawaii and Western Branch chapters of the American Public Health Association, the Hawaii Chapter of the American Red Cross, and the Lanakila Crafts. He has been a member of the Governor's Committee on Employment of the Physically Handicapped. He is a past President of the Hawaii branch of the American Society for Public Administration.

Our warmest good wishes go with Dr. Bernstein in his retirement from the position he has occupied so effectively. *Aloha oiaio,* Leo!

## The Autumn of Our Sorrowful Discontent

Sad it is indeed that we physicians, who have been so outrageously exploited by others for their personal gain, should stand now, in this, our sorrowful "Autumn of Discontent," so appallingly ignorant of the source of our strength. Sad it is indeed also, that we seem to be constitutionally incapable of learning from the experiences of others, but go blindly on, under the banner of "individualism," making the same old mistakes others have made in the past. My brothers, "we must learn from the mistakes of others, for we do not have time to make them all ourselves."

It was in the second half of World War II when American armies clashed furiously with the enemy in Western Europe. Casualty lists were long, and thousands of American families had lost something that could never be restored to them on this planet Earth. It was then that John L. Lewis called his United Mine Workers out on strike, and the soft coal miners filed out of the pits. The screams of anguish of the American people were immediate and they were echoed in the halls of Congress, where our representatives roared "draft the striking miners into the armed forces." The President of the United Mine Workers bided his time, and then answered in only six words, but their truth was so apparent that no thinking person could disagree. John Llewellyn Lewis answered in his strong and resonant voice: "You can't dig coal with bayonets." "You can't dig coal with bayonets"; how devastatingly true.

To paraphrase John Llewellyn Lewis: "You can't heal the sick with bureaucrats." Lyndon Johnson and his socialist-oriented Welfare State which he calls "The Great Society" cannot heal the sick. No; with all the billions of dollars of the taxpayer's money at his command and all the millions of government workers on the public payroll, he still "can't heal the sick." Blue Cross cannot heal the sick. Blue Shield, "the doctor's own plan,"

Reprinted with permission from Virginia Medical Monthly, Vol. 93, Pages 627-629, November, 1966.

(how ironic that is) cannot heal the sick. Federal bureaucrats cannot heal the sick. Nobody but doctors can heal the sick, and that is the source of our very considerable strength, if only we realized it; if only we had the courage to stand fast. To stand as Thomas Jonathan Jackson stood on the Henry House Hill while a brave but disorganized army fled past him to the rear, when General Bee in a desperate effort to stop the retreat roared: "There is Jackson standing like a stone wall; rally behind the Virginians." That gallant army stood, and turned defeat into victory at Manassas.

Would that we in medicine had a Stonewall Jackson to rally behind today; if we only had the courage to stand fast when defeat seemed inevitable! If we only had the courage to stand and the discipline that would be required for a stand, no power on the face of this earth could stop us from turning the present defeat into certain victory.

We live in perilous times; "Gentlemen may cry 'Peace, Peace' but there is no peace." Perilous times indeed for our individual freedoms, which were purchased with the blood of our forefathers and bequeathed unto us, without charge or sacrifice, for safekeeping. Perilous times for our people who are led blindfolded down the road to Socialism by their elected representatives who masquerade as Liberal Republicans or Liberal Democrats. Walt Whitman's prophetic words echoing down through the years are frightening in their import: "No people in the history of the world who ever voluntarily gave up their freedoms have ever had those freedoms restored to them."

We Doctors of Medicine have a long tradition of individualism extending back to the birth of the Republic, and of which we can be justly proud. We have never been fitted into any mold; we have never, like Wamba, worn any man's collar. But my fellow physicians I say to you now with all the sincerity at my command that the days when we could indulge in the luxury of political individualism are past, and should be buried "with all due respect."

We have, for too long, been content to heal the sick, while a plethora of voices spoke for us and to which no one listened, least of all our elected representatives. For they know only too well that in fragmentation there is weakness. Regardless of what is right or what is wrong, no politician listens to weakness. If there had been a plethora of voices all speaking for the United Mine Workers, and all with divergent aims, our Government would most certainly have "dug coal with bayonets." Weakness speaks with many voices and no one listens; strength speaks with only one voice and everyone then *must* listen.

For medicine to speak with one voice and to act in unison requires discipline, just as an army must have discipline to attack in unison on one front to "turn defeat into victory." This discipline that is required will mean the loss of some of our minor freedoms. It will mean the loss of the freedom to disagree for disagreement's sake. It will mean the loss of the freedom to disagree when medicine's one voice says: "You can't heal the sick with bureaucrats." But I assure you now that if we don't willingly give up these minor freedoms so that we can speak with one powerful political voice that *will be listened to,* then we had better prepare ourselves now for the complete loss of all those freedoms that our forefathers died to give us and gentlemen *I exaggerate not.*

In unity there is strength; in disunity there is weakness. Neither our government nor any government will listen to a voice that leads from weakness. Neither our government nor any government *can afford not to listen* to a voice that leads from strength. I urge you to remember now when our entire future hangs perilously in the balance that "A house divided against itself cannot stand."

The emergency is upon us; the time for action is now. If we are to survive as free men we must abandon our petty political ambitions; we must forego the jockeying for minor political advantage; we must speak with one voice and that voice must be powerful, insistent, consistent, unyielding. This will take courage but without courage, there can be no victory, and no survival and as sure as the sun rises we shall all end up salaried vassals of the State. Now is the time for us to take seriously Benjamin Franklin's words, for they are just as true for us today as they were for him in that hot July of 1776. *"We must all hang together or assuredly we shall all hang separately."* ■

THOMAS J. MCKENNA, M.D.

608 U.S. Bank Building, Johnstown, Pa.

# This Is What's New!

• The **gamma ray scintillation camera** makes it possible to follow a radioactive bolus injected into the antecubital vein through various parts of the body. Technetium 99-M is used as a source of radioactivity, and as it moves to the arterial side, **arterial occlusions, aneurysms,** and a differential **renal blood flow** can be demonstrated. Also, **mediastinal masses** can be distinguished from vascular structures. When this procedure is perfected, it may be unnecessary to depend upon catheterization studies or intra-arterial injections of radiopaque dyes for various occlusive arterial diseases. (*Radiology* [Apr.] 1966.)

• **Chronic hypertension** induced by **clipping renal arteries** in monkeys results in patchy arterial stasis of the cerebral arterioles with the same distribution pattern as is seen in **fibrinoid necrosis.** (*American Journal of Pathology* [Aug.] 1966.)

• **G-myeloma proteins** are **heterogeneous,** with the individual protein containing as many as eight light chains and nine heavy chains. (*Science* [June 17] 1966.)

• **Needle biopsy** of the **thyroid** gland is an entirely satisfactory method of diagnosing various thyroid abnormalities. In 83 per cent of biopsies performed, adequate tissue was examined. A definitive **diagnosis** could be made **93 per cent** of the time. Needle biopsy would be **contraindicated** in clinically solitary nodules and in suspected **papillary carcinoma.** (*Surgery, Gynecology and Obstetrics* [May] 1966.)

• The **blinking** of a **mosquito bite** led to the diagnosis of **patent ductus arteriosus** in Denver. It was noted that a mosquito bite on the leg of an infant "blinked." The blinking was caused by a widened capillary pulse pressure and the cause for this was found to be patent ductus arteriosus. (*Arch. Derm.* [Dec.] 1966.)

• Fifty consecutive deaths due to **bleeding peptic ulcer** occurred mostly in patients **over 55.** Repeated hemorrhages were the rule. Median number of hemorrhages was five and the median day of death was the sixth. The commonest therapeutic errors were **too little blood** transfused at **too slow a rate,** and **poor timing of surgery.** (*Ann. Surg.* [Nov.] 1966.)

• Of some 12,000 women screened for **carcinoma of the breast** in California by x-ray mammography and clinical examination, it was discovered that the most sensitive screen in women older than 50 was **mammography** and in women less than 50 was **palpation** of the breast. (*Cancer* [Nov.] 1966.)

• Group A beta hemolytic **streptococci usually associated with sore throat** have been found to be responsible for **perianal cellulitis** in ten patients presenting with erythema of the involved area. The infection responds promptly to **penicillin.** The epidemiology has yet to be worked out. (*Amer. J. Dis. Child.* [Dec.] 1966.)

• **Arcus senilis** correlates significantly with the serum **cholesterol** and **phospholipids** but not with triglycerides or total lipids. (*Arch. Ophth.* [Sept.] 1966.)

• Twenty-two patients had their **ganglia** injected with small amounts of **hydrocortisone** after aspiration. In 19 patients the ganglia disappeared with no observable recurrences two months to five years after treatment. In three cases the ganglia recurred and were eventually treated by excision. (*Amer. J. Surg.* [Nov.] 1966.)

• A group of **elderly individuals living in squalor** were studied in England. It was believed that this syndrome expressed **withdrawal** from the community and **resentment towards society** by the elderly persons so affected. About half presented psychotic behavior. There was absence of mental deficiency and they usually had domineering, independent personalities. They usually refuse to accept any type of help, and admission to hospital was unsatisfactory. Day care and domiciliary treatment were recommended. (*Brit. Med. J.* [Oct. 29] 1966.)

• The **mode of cessation** of **anticoagulant therapy** apparently does not alter the course of **ischemic heart disease** according to English investigators. Over 200 patients on anticoagulant therapy who were noted to have stopped their anticoagulant in various ways had no evidence that new myocardial infarcts or death from heart disease was influenced by the manner in which the anticoagulant was stopped. (*Brit. Med. J.* [Aug. 13] 1966.)

F. I. GILBERT, JR., M.D.

HAWAII MEDICAL JOURNAL

# In Memoriam—Doctors of Hawaii

This is the sixty-fifth installment of In Memoriam—Doctors of Hawaii.

## Charles Robert Blake

Charles Robert Blake was born in Visalia, California, in 1868 and was a graduate of the University of California Medical School in 1891. He was licensed to practice in California the year he graduated and presumably was in practice there until September 14, 1897, when he arrived in Honolulu aboard the S.S. "Australia." The ships' passenger list had him down as a U. S. citizen, aged 28, last residence California, making the trip for pleasure. Although Dr. Blake came for pleasure, he applied for a position with the Hawaii Board of Health less than a month after his arrival. While waiting for an opening, he worked as a pharmacist at the Benson Smith Company in Honolulu. On December 23 he accepted a position as physician for the Oahu Plantation. Early in 1898 he was appointed physician at Ewa Plantation to replace Dr. John Weddick, a position he held in addition to his duties at Oahu Plantation.

In June, 1898, Dr. Blake was married to Miss Lillian McKibben of San Francisco at the Methodist parsonage in Honolulu. One son, Herbert E., was born to the doctor and his wife.

After two and a half years at Oahu and Ewa plantations, the Board of Health sent him to the Puna district on Hawaii where he was also physician for Olaa Plantation. In 1901 Dr. Blake was appointed to the honorary staff of the Hilo Hospital, and in August of the same year he became auditor for the Keaau Land and Planting Company.

In December, 1901, the Board of Health granted Dr. Blake a six-month leave of absence from his duties as government physician, and on January 3, 1902, he and his family left for San Francisco aboard the "Rhoderick Dhu." He did not return to the Islands but located in Richmond, California, where he engaged in private practice. On March 21, 1910, Dr. Blake was appointed City Health Commissioner for Richmond. For 34 years he served in this capacity, and during that time there was never a major epidemic in the city and the health of the residents ranked with the best in the state.

Dr. Blake died in Richmond on December 27, 1944, at the age of 76.

He was a member of the Contra Costa County Medical Society, the California Medical Society, and the American Medical Association. He also belonged to the McKinley Lodge of Masons, the Royal Arch Masons, the Richmond Commandery of the Knights Templar, the Ahmes Temple of the Shrine in Oakland, the Richmond Pyramid of Sciots, the Richmond Elks Lodge, and the Miramar Chapter, Order of Eastern Star.

## Horace D. Laidlaw

Horace D. Laidlaw was born about 1860 and was a graduate of the University of California Medical Department, San Francisco, in 1880.

Dr. Laidlaw first visited the Islands when he was serving as ship's surgeon aboard the S.S. "Zealandia." In November, 1891, he left the sea to locate at Spreckelsville, Maui. Early the following April he returned to San Francisco to be married. After the wedding, the doctor brought his bride to "their pretty new home situated on the largest plantation on Maui," to quote a local paper. Dr. Laidlaw practiced in Spreckelsville until September, 1894, when he left the Islands.

Shortly before his departure Dr. Laidlaw wrote to the Board of Health saying that he had formulated a treatment for leprosy which he was anxious to test. He requested that he be allowed to try his treatment on selected patients at the receiving hospital in Honolulu, and, in the event, that these patients were improved or cured that he be allowed to continue the treatment. His request was referred to the Board's committee on leprosy, which recommended that all experiments should be conducted under the direct supervision of the Board of Health with the Board's full knowledge of the composition and method of administering all remedies. Apparently, the doctor did not care to follow the recommendations laid down by the committee for he and Mrs. Laidlaw left for San Francisco on September 27.

Locating in San Francisco, he returned to his former position and served as ship's surgeon on the S.S. "Mariposa." Eventually he became chief surgeon for the Oceanic Steamship Company. The doctor and his wife had one daughter born in 1895.

After a long illness, Dr. Laidlaw died in San Francisco on August 2, 1905, at the age of 45. ■

There is no doubt of it—the modern-day practice of medicine is due for a radical shake-up.

The biggest single factor that will bring about the "New Medicine" is the recent advance in medical technology.

### END OF AN ERA

We are seeing the end of the era in which the physician could do relatively little to ward off death, disease, and crippling disability, although he was able to do a great deal in the giving of palliation and comfort on a person-to-person basis. Generally speaking, what a doctor was able to offer his patient was accepted as being enough if he did all that could be done, within his professional capabilities, and within the patient's locale. "Freedom of choice of physician," and "the doctor-patient relationship" are the two clichés that could be applied to that era.

This is not to say that someday there will be no more of this personal relationship; only that there will be less emphasis placed on it. The past, the present, and the future merge into each other, of course, but, for the sake of a perspective, they can be divided. In contemplating philosophically the practice of our profession, we must make these separations.

The present is always in a state of limbo, as we move from the past to the future. It is like the twilight, moving steadily forward across the face of the earth. Our particular present, however, seems to us to be crossing a major divide, perhaps because the past era of medicine has been such a long one, and because the transition to the future appears to be a rather violent one.

The advent of "Medicare" was violent; the imminent impact of "Heart Disease, Cancer and Stroke" may be even more so, in terms of upsetting tradition in the practice of medicine.

### THE MEDICAL TEAM

Modern medical technology, primarily manifesting itself in specialization and superspecialization, has advanced so rapidly and to such a degree, that it must be simply appalling for any medical student to contemplate. Certainly, any intern who figures to go into general practice must settle his mind in favor of being a medical counsellor to people. His will be the practice of the art of medicine. The intern who is more interested in the science of medicine must naturally set his sights on specialization. Man's intellect is not limitless; his brain is encompassed by a hard, bounding, cranial box. Superscientists are very rare. The accumulation of scientific knowledge is so large that, for example, internists who limit their field to cardiology become as lost in treating ulcerative colitis as a surgeon is in delivering a baby!

So, as the world of medical science expands before us, it becomes more and more obvious that, in order to treat the whole man again, we must pool the resources of our several brains. This has already been done—in business, government, space acronautics, and even in our own field of medicine: the team in open-heart surgery, for example.

### "CENTERS OF EXCELLENCE"

The intent of the Congress in formulating the "Heart Disease, Cancer and Stroke" program is probably exactly along the lines of thought described above. The program's conceptual basis centers around medical teams of experts equipped with the most modern of facilities and equipment, to form "Centers of Excellence." This was formulated while the large mass of us practicing physicians had our noses applied to the grindstone of the personal practice of medicine. We would like to think that a lay Congress did not dream this up on its own—that it had medical direction from some in our midst who were looking to the future of medicine.

This January, our Association's President, together with three other leaders of our medical and lay community, will join leaders from other states, in Washington, to confer on the implementation of this concept of "Centers of Excellence."

Some envision an Ivory Tower in each of the major population centers of the United States—a giant building complex, into which people-patients may, or even *will,* be fed, to come out clean or cured.

Others can see in this the development of team medicine *par excellence,* distributed and made available centrifugally, so that almost no citizen will suffer from the lack of what we are proud to offer professionally: the very best in modern medicine.

It behooves each of us, young and old, neophytes and emeriti, to watch this development of the future of medical care with interest, perceptiveness, and cooperative participation. ■

J. I. Frederick Reppun, M.D.
Editor, *G. P. Bulletin*

HAWAII MEDICAL JOURNAL

# Notes and News

## Elected, Appointed, and Honored

We hasten belatedly to congratulate our Doctor-Editor-Activist **Harry Loren Arnold, Jr.**, on his silver anniversary as Editor of this fine JOURNAL and on his nomination by the AMA Section to the American Board of Dermatology. We note from the "Advertiser" photographs of Harry 25 years ago and now that the dashing, full haired, scholarly mien has matured, is thinner domed, but looks every bit the fighter with set jaw, firm mouth as if he was ready to debate the merits of fluoridation with the camera.

We are also proud of our **George Mills**, who made a praiseworthy showing in the recent Lt. Governorship race, and congratulate him on receiving the David Malo Award, given annually to an individual of Hawaiian ancestry who has performed outstanding community service. He certainly has.

Deserving **Frank Bruce** is the new President of the Hawaii Society of Internal Medicine. **Thomas Lau** is Vice-President and **Ray dellay** Secretary-Treasurer. The American Academy of Pediatrics recently elected **Gloria Nano Naiino-Badua, Betty Soo, Hiroaki Tottori, Donald Pfeifer**, and **Sidney DeBriere** as Fellows, and **Walton Shim** as Surgical Fellow. The American College of Surgeons also elected some Fellows: **Frank Akamine, Edward Jim, Hideo Oshiro**, and **Clarence Sakai.** Initiation ceremonies were held by the Hawaii Chapter at the Pacific Club. The new officers of the Hawaii Chapter, American Academy of General Practice are President **Robert Chung**, President-elect **Patrick Walsh**, Secretary **Larry Wong**, and Treasurer **Felix Lafferty**. The new councilors are **Fred Lam, Jr., Kiyoshi Inouye, Vernon Boido, Alan Laning**, and **Fred Reppun.**

On the school front, **Clarence Chang** is the new Vice-chairman of the University of Hawaii Board of Regents and **John Milnor** the new Vice-president of the Pohukaina School PTA. Humanitarian **L. Q. Pang** recently reccived a recognition award in honor of outstanding service to Big Brothers of Hawaii. We also note that **Ed Furukawa** and **Toru Nishigaya** are advisors to this worthy organization. Our hard working PR chairman, **Andy Ivy**, is the new President of the Aulea Swim Club on the windward side.

After 24 years of public health service, **Leo Bernstein**, retiring Director of the State Department of Health, was honored at a testimonial dinner. He can now enjoy a well-deserved rest. Also after 25 years of service, **Edmund Tompkins**, retiring Superintendent of Kula Sanatorium was honored at a farewell luau. We hope they follow the example of our peripatetic 66-year-old **Herbert Bowles**, who apparently retired several years ago, but appears to be busier than ever. After serving last year as gynecological consultant in the frozen wastes of northwest Newfoundland, he recently completed a tour of the African nations in similar capacity to perhaps thaw out a little, and returns to Kenya this month to work.

On the political front, **Clarence Fronk**, who also retired many many years ago, was reappointed as Chairman of the Board of Parks and Recreation and "Blue" Nishigaya, Chairman of the Advisory Council on Hospitals and Medical Facilities, was recently appointed to the policy board of the Hawaii State Vocational Rehabilitation Plan. Louis Rockett was appointed Maui member of the State Board of Medical Examiners. (May we quietly comment that we were aghast to learn that our controversial nonmember colleague, **Willis Butler**, last year replaced **Harry Arnold, Jr.**, on the same board. Politics, politics, politics.)

**Yorio Wakatake** has many interests. We knew that he was a black-belter with the local Aikido organization, but were still astonished to learn that he is the newly elected President of the Associated Evening Students of the Hawaii Chinese Educational Association. Naturally, the other officers are all Chinese.

## Travellers and Social News

We are continually amazed at the antics of our gad-about neurosurgeon **Ralph Cloward**, who maintains an active practice and still manages to sneak off to various parts. In February, he lectured at the Interurban Neurosurgical Society in Las Vegas, Nevada. During the second week in March, he was visiting professor at the University of Oregon Medical School. On March 26, he was in St. Louis, Missouri, operating on an unusual spinal tumor. The first week in June found him conducting the "Seminario de Traumatologia Y Ortopedia" in Mexico. In July, he participated in the "Simposio Internacional de Neuro-Traumatologia" at Bogota, Columbia. In October, he conducted another international symposium at the University of Madrid, Spain. In November,

### CHARLES TAKESHI TAHARA, M.D.
### 1917-1966

Charles Takeshi Tahara was born in Hilo on January 21, 1917, the son of Churyo N. and Kotoji Tahara. After graduating from the Hilo High School in 1935, he attended the University of Hawaii for three years. He completed his undergraduate work at Northwestern University and received his M.D. from Temple Medical School in Philadelphia in 1943. He took his internship and residency in urology under Dr. Elmer Hess at St. Vincent's Hospital in Erie, Pennsylvania, and followed that with a staff position at the Hamot Hospital, also in Erie. He was well known throughout Western Pennsylvania and was on the staff of the Ridgeway Hospital and the Andrew Kaul Memorial Hospital, where he was head of the Urology Department, at the time of his death from a heart attack on November 23, 1966, at the age of 49.

Dr. Tahara is survived by his wife, the former Doris Fritz; two sons, Charles P., and Martin; four daughters, Sandra, Joan, Nancy, and Libby; and by a brother, Glenn, and a sister, Mrs. Yoshiko Hamada, both of Oahu.

he presented a paper at the Clinical Meeting of the AMA in Las Vegas. Everything was uneventful except that he barely missed being blown up when a sizable bomb was exploded in the basement of the American Consulate. Having seen this human dynamo wear out several surgical assistants during the course of his usual ten-hour operations, we timidly suggest for posterity's sake that he be evaluated biochemically, immunologically, neurologically, and even psychiatrically, to determine where this inner strength stems from. Since eunuchs are never bald, we may have a clue in Ralph's naked pate.

The **George Garises** spent two and a half months touring Europe by car. George ostensibly attended meetings in Amsterdam and Madrid while his wife collected fashions. **Homer** and **Bob Benson** have a physician brother, George, who spent the holidays with them on his way home to Texas after a trip through Russia. We learned that "Homer and Robert share an office and never leave on vacation at the same time and even take turns attending medical meetings." Perhaps this is a welcome relief from each other. Even brotherly love can only be stretched so far.

## Bulletins

We learned that psychiatrist **Bill Cody** is looking for fellow musical amateurs who play string instruments and who are interested in "assaulting" piano trios, quartets, quintets, etc., two or three times a month. For the skeptics, he promises that these would be strictly fun and not therapy sessions.

It seems that poi-loving pediatricians from the Straub, Kaiser, and Fronk Clinics and the Medical Group are cooperating in a project to evaluate poi as a diet food for allergic babies. The research will supplement the findings of Jerome Glaser, pediatrics professor at University of Rochester. The Chamber of Commerce anted up $10,000 in 1965 and an additional $2,000 in October of last year. Some 64 poor babies have been surveyed and another 83 are now being tested. Since we are not particularly fond of the stuff, we hesitate to ask if sugar and milk can be added, but then we don't care for Pablum either.

Plethoric psychiatrist **Shepard Ginandes** advocates "peak experiences" without the use of chemicals like LSD. He advises, "The best insurance that you will have peak experiences in your life is to be ready for them. Start by getting your hang-ups solved and by looking at yourself in doses you can stand . . . When you have passed that, you'll find peak experiences happening to you." By peak experience, Shep means "the feeling that suddenly everything has enormous intensity. He has a feeling of grace and effortlessness in doing everything and a feeling of not wanting anything because all his needs are fulfilled." Now, you really lost us, brother.

The Maui County Society adopted a code of ethics to guide physicians and news media but judiciously decided against adopting the Honolulu practice of using prearranged code numbers for paging. We note that these numbers become a decided nuisance to remember as we grow older too.

The **Tom Fujiwaras** were winners of the "Best in Cypripedium" (whatever he, she, or it is) at the All Hawaii Flower Show at the HIC.

## Professional Moves

We feel that the mental health of this community is finally on the mend with the welcome arrival of several psychiatrists. Pediatric psychiatrist **Leigh Sakamaki** started private practice at 1441 Kapiolani Blvd, **Robert Levy** joined the University School of Public Health, **Joseph Lerner** filled the long vacant spot of State Hospital Medical Administrator, and **Quang-Hsi Hu** was appointed unit chief of the Diamond Head Unit. Our capable **Audrey Mertz,** who has been holding down three administrative positions and a full-time job as mother and wife since **Bob Spencer's** resignation in March, can now devote full time to her post as Executive Officer of the Mental Health Division.

In November, pediatric cardiologist **George Nagao** joined the Medical Group, internist **Rose Wong** shifted from Queen's to the York International Building, dermatologist **Bob Kim** tiring of solo practice joined the Straub Clinic, and **Nathan Shklov** relocated to 94-748-B Hikimoe St., Waipahu. It was formally announced in November that **Ralph Platou,** Tulane University pediatrics professor, will return to Hawaii as Professor at the University of Hawaii Medical School and Medical Education Director of Kauikeolani Children's Hospital.

December saw the appointment of soft-spoken, likable **Walter Quisenberry** as State health chief, replacing retiring **Leo Bernstein.** Plastic surgeon **Allyn McDowell** opened his office at the Alexander Young Building.

On Maui, anesthesiologist **Billie Fern Strother** was heralded as the only female medical practitioner, but not for long, for less than a month later, **Dorothy Wood** moved in from ten months on Molokai to join the Lahaina Staff of the Maui Medical Group and become Maui's second woman physician. Maui is suddenly being beset by the fairer sex.

## Sportsmen

*Divoters:* In October at the Waialae, the **Bill Hartwells** won the foursome best ball with a sparkling 59. **"Toots" Fujii** with his juiced handicap won B flight with a 80-12-68. Remarkable **Sam Yee** continued his hot streak and finished 3 up to win the match vs. par tournament. "Toots" and **Roy Tanoue** captured team medal with a net 140. In November, **Sam Yee** won the monthly ace with a creditable 77-8-69. **K. S. Tom** triumphed in C flight with 92-17-75. Steady **Bill Ito** won B flight honors with 84-13-71. **Roy Tanoue** and **"Toots" Fujii** again won team medal with a 141. On an unforgettable day in November, golf stylist **Marquis Stevens** took his usual casual swing with a No. 5 iron on the 7th hole at the Oahu Country Club. He watched the shot sail towards the green and hardly blinked as it dropped into the hole for an ace. In December, the **Francis Kaneshiros** tied with two other teams in the foursome best ball. **Roy Tanoue** again tied for first place in the individual medal. **Albert Ho** paced A flight with a 79-10-69. **Bill Ito** and **Richard Chun** took team best ball. **Ralph Cloward** took time off from his gallivanting to shoot an 80-10-70 to tie for 3rd place in the 1966 Hawaiian Golf Association's State Senior Golf tournament. We noticed that **Bill Walsh** was entered, but failed to see his scores. At the Ala Wai, **Hideo "Slugger" Oshiro** made his comeback debut by tying for 1st place in the November-December Tournament. **Frank Fukunaga** conveniently dropped to 10th place after winning the previous tournament. Being handicap chairman has its advantages. In B flight, **Dick Omura** won the bimonthly trophy and **Kyuro "Chi Chi" Okazaki** placed 2nd.

*"Racketeers":* Indefatigable **Howard Liljestrand** won a feature match at the Iolani Tennis Club championships on November 14 while aging **"Yosh" Yoshida** was trounced by a mere 14-year-old to the tune of 6-1, 6-4. **Shig Horio** also placed and lost. Next week, "Yosh" and **Leabert Fernandez** teamed to lose in the Iolani Tennis Club's Men's Singles Match (How about that?). **Shig Horio** and **Alex Roth** were teamed and won the first round and lost in the second. The "Sunrisers" (16 fanatics who start their play at 7 o'clock Sunday mornings) completed their round robin series, with **Hiro Tottori** and **Mits Yokoyama** winning A flight and **Cal Sia** and **Ben Tom** placing second.

HMA Tennis tournament chairman, **"Yosh" Yoshida,** is encouraging all aspirants to start practicing for the matches to be held in May. He plans several flights, including an open flight in which one chooses his own partner. He and **Leabert Fernandez** plan a clean sweep, but perennial losers **Charley Ching** and **Ben Tom** feel otherwise. We have it on record that "Yosh" recently made the statement that perhaps Charley and Ben should try again in another five years.

*continued page 257*

HAWAII MEDICAL JOURNAL

# New Members



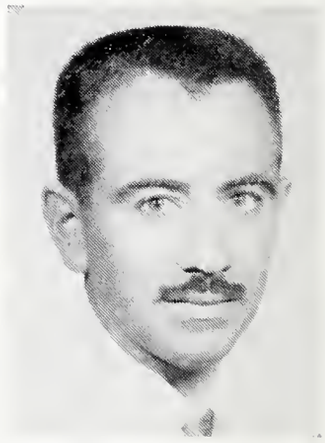
**Victor Hay-Roe, M.D.**
1441 Kapiolani Blvd., Room 520
Honolulu, Hawaii 96814

PLASTIC SURGERY
University of Alberta, Edmonton, Alberta—1955
Internship—University of Alberta Hospital—1955-56
Residency—The Queen's Hospital, Honolulu—1956-59
University of Pittsburgh Medical Center—1963-66



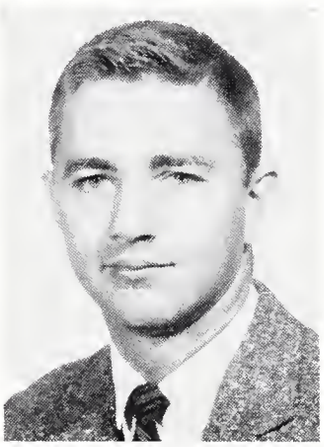
**Verne Lewis Adams, M.D.**
Pahala, Hawaii 96777

GENERAL PRACTICE
University of Oregon—1939
Internship—Good Samaritan Hospital
Fellow of American Society of Abdominal Surgeons



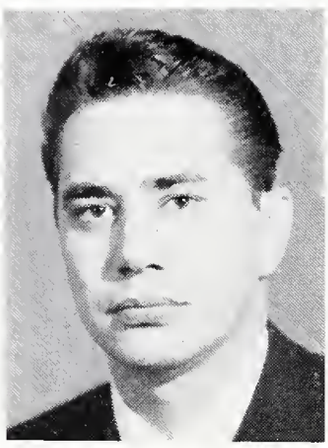
**Miguel Rivera Rivera, M.D.**
Hawaii State Hospital
Keaahala Road
Kaneohe, Hawaii 96744

NEUROLOGY-PSYCHIATRY
University of Mexico—1955
Internship—St. Francis Hospital, Honolulu, Hawaii—1954-55
Residency—Psychiatric Receiving Center, Kansas City, Missouri—1956-59
Jackson Memorial Hospital (Neurology), Miami, Florida—1959-62



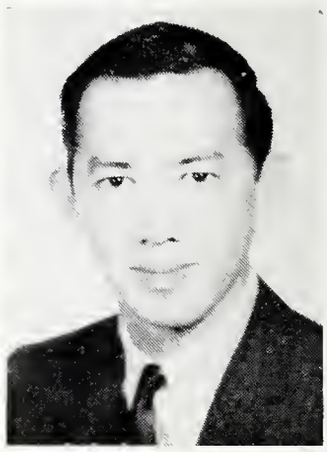
**Harry Arbaugh Lee, M.D.**
305 Wailuku Drive, P. O. Box 606
Hilo, Hawaii 96720

OBSTETRICS-GYNECOLOGY
University of Colorado—1961
Internship—Santa Clara County Hospital, California—1961-62
Residency—University of Oregon—1962-66



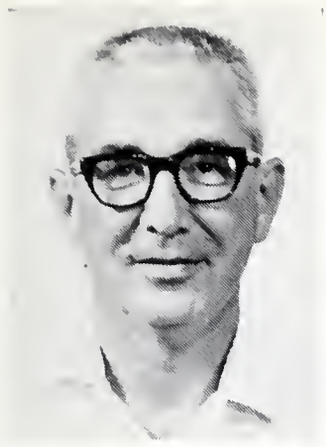
**Hamilton M. Winston, M.D.**
Kailua Professional Center, Suite 506
30 Aulike Street, Kailua, Hawaii 96734

OBSTETRICS-GYNECOLOGY
University of Oklahoma School of Medicine—1960
Internship—Saint Anthony Hospital, Oklahoma City—1960-61
Residency—Kapiolani-Queen's-St. Francis, Honolulu—1963-66



**Gordon Charles Ontai, M.D.**
1697 Ala Moana Blvd.
Honolulu, Hawaii 96815

OBSTETRICS-GYNECOLOGY
Marquette University—1960
Intership—St. Mary's Hospital, San Francisco—1960-61
Residency—San Francisco Catholic Hospitals—1963-66



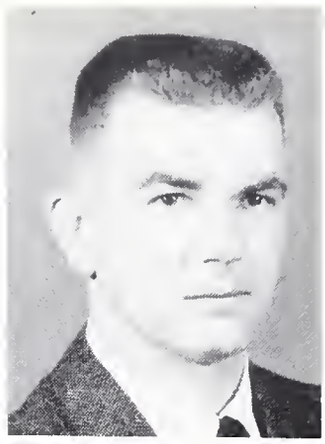
**Fred L. Goff, M.D.**
305 Wailuku Drive (P. O. Box 606)
Hilo, Hawaii 96720

GENERAL PRACTICE
Ohio State University—1952
Internship—Wm. Beaumont Army Hospital—1952-53



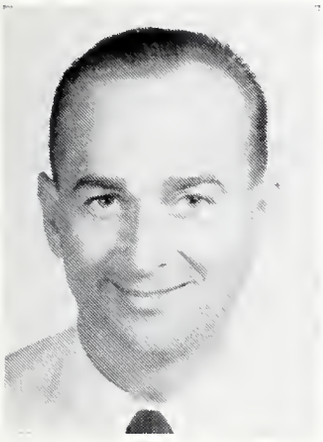
**Allyn J. McDowell, M.D.**
254 Alexander Young Bldg.
Honolulu, Hawaii 96813

PLASTIC SURGERY
Washington University—1943
Internship—Barnes Hospital—1943-1944
Residency—Barnes Hospital—1944-1945



**Reginald S. Carvalho, M.D.**
305 Wailuku Drive (P. O. Box 606)
Hilo, Hawaii 96720

GENERAL PRACTICE
Creighton University School of Medicine—1961
Internship—U. S. Army Tripler General Hospital—1961-62



**Lothar M. Varady, M.D.**
Diamond Head Mental Health Center
550 Makapuu Avenue, Honolulu 96816

PSYCHIATRY
Karl-Franzens University, Graz, Austria—1952
Internship—Elizabeth General Hospital, Elizabeth, New Jersey
Residency—Delaware State Hospital—1956-57
Bellevue Hospital, New York—1957-59

ERRATUM: In the last issue the pictures of Drs. Juris Bergmanis (neurosurgeon) and James Hall Steward (urologist) were reversed. Our sincere apologies.

# *County Society News*

## Hawaii

Dr. Norman Goldstein from Tripler was a guest at the October 20 meeting. He spoke on "The Diagnosis and Therapy of Common Skin Disorders." Dr. Helms announced that the annual Christmas party will be held at the Mauna Kea Beach Hotel on December 10. Volunteers were solicited to act as speakers to the PTA's who had asked for doctors to talk on fluoridation. It was pointed out that the HMA message referred to benefits for Honolulu's children and adults. Dr. Helms said he would write to Dr. Ivy and request brochures, etc., which may be of assistance to physicians talking to local groups. Drs. Eklund and Mitchel were suggested as potential candidates for the office of HMA Councilor. Dr. Caldwell advised that the Society was spending in excess of $350 a year for journals and tapes for the library at the Hilo Hospital. The matter was referred to the Library Committee. After some discussion of members' sponsorship of guest speakers, it was voted that the Secretary should advise guest speakers that their reimbursement was not to exceed $60.50. A plea was made that business matters be solved by the President and Executive Committee in order to leave more time for the scientific speakers. Four new members were voted into the Society—Drs. Verne L. Adams, Reginald Carvalho, Fred L. Goff, and Harry Lee. The St. Francis Nurses' Alumni joined the physicians to hear Dr. Goldstein's presentation.

* * *

Vice President Best presided over the November 17 meeting. The Treasurer made his report. $1,500 will be added to the Scholarship Fund and $1,000 allocated towards the Christmas party. The new HMA and AMA dues structure was reported. The Nominating Committee's proposed slate was announced, and a unanimous

*continued page 246*

HAWAII MEDICAL JOURNAL

# Book Reviews

## Synopsis of Obstetrics, 7th Ed.

*By Charles E. McLennan, M.D., 471 pp., $6.85, The C. V. Mosby Company, 1966.*

DR. MCLENNAN has updated his excellent synopsis of obstetrics. This seventh edition includes the latest techniques in the diagnosis and treatment of the sensitized pregnant Rh negative woman. For example: transabdominal amniocentesis and spectrophotometric scanning of the amniotic fluid are mentioned, as is fetal transfusion in utero. The use of hypertonic glucose or saline in therapeutic abortion is also included.

While by necessity the book lacks detail in many places, it is excellent as a quick review or as a textbook when one hasn't the time to read through the more weighty volumes.

FRANCIS H. SOON, M.D.

## ★Blood Diseases of Infancy and Childhood, 2d Ed.

*By Carl H. Smith, M.A., M.D., 800 pp., $22.00, The C. V. Mosby Company, 1966.*

THIS IS THE second edition, revised, of an excellent textbook on pediatric hematology. Much new information and knowledge are added. The chapters on origin and development of blood cells and blood changes during the postnatal and early infancy and childhood periods are well done. Special hematological problems seen in pediatric practice, such as exchange transfusions, are discussed in detail. While the bibliography is not so extensive or detailed as in certain other general hematology texts, sufficient references are included for general purposes. In summary, this textbook covers the special field of hematology in the infancy and childhood periods very well, and serves as an excellent text in this area. It is highly recommended to all general practitioners, pediatricians, and hematologists.

ROBERT T. S. JIM, M.D.

## ★Pediatric Therapy, 2d Ed.

*By Harry C. Shirkey, B.S. (Pharm.), M.D., F.A.A.P. (Editor), 1234 pp., $18.50, The C. V. Mosby Company, 1966.*

THIS IS ONE of the most complete and comprehensive outlines of pediatric therapy published to date, and an absolutely essential part of the library of anyone who practices pediatrics, even on a restricted basis. The material in the book not only relates to specific drug therapy, but gives the background of the various types of most modern therapy of any and all pediatric conditions, both common and rare. It is enlarged considerably from the first edition, but the added chapters only increase the value in scope of coverage of therapy, rather than adding to the bulkiness of the textbook. This book is heartily recommended for all pediatricians, general practitioners, and as a reference book for anyone who wishes to be brought up to the most current and concise methods of pediatric therapy. It was a pleasure to review this book, and I intend to purchase a copy for my own library.

GEORGE M. EWING, M.D.

* Means highly recommended.

## ★Williams' Obstetrics, 13th Ed.

*Edited by Nicholson J. Eastman, Louis M. Hellman, with the collaboration of Jack A. Pritchard with the assistance of Ralph M. Wynn, 1182 pp., $18.75, Appleton-Century-Crofts, 1966.*

THIS IS TRULY one of the best textbooks in obstetrics. In the five years since the last edition, the authors have thoroughly revised many portions. Much new current information pertinent to basic and clinical knowledge has been added to enhance the techniques and skills of management of normal and complicated obstetrics.

There is also a brief coverage of various diseases encountered during the reproductive years.

Adequate references enable one to quickly obtain more detailed information.

Chapter bibliographies are very good and should be a stimulus to student and practitioner alike.

S. J. BUIST, M.D.

## Advances in Cardiopulmonary Diseases, Vol. III

*Edited by Andrew L. Banyai, M.D., F.C.C.P. and Burgess L. Gordon, M.D., F.C.C.P., 348 pp., $12.50, Year Book Medical Publishers, 1966.*

THIS THIRD VOLUME of a scheduled series represents selected lectures given at postgraduate programs sponsored by the American College of Chest Physicians. While it offers a spectrum, the volume suffers from lack of cohesion and organization. Much of the material covered may be found in recent standard textbooks or in review articles of current journals. For the purpose of a survey in the field, this series may be worthwhile as part of a large reference library.

BERNARD J. B. YIM, M.D.

## Carcinoma of the Alimentary Tract: Etiology and Pathogenesis

*Edited by Walter J. Burdette, A.B., A.M., Ph.D., M.D., 233 pp., N. C., University of Utah Press, 1965.*

THIS IS A TIMELY volume which reviews the epidemiology and pathogenesis of human gastrointestinal carcinoma in its three most common sites—esophagus, stomach and large intestine. It is especially valuable to the pathologist and surgeon in Hawaii because these tumors are so common here. The comparative pathology of naturally occurring animal tumors and descriptions of experimentally induced tumors are also included. Each chapter has a separate author and there are surprises and useful nuggets in almost every section. For example, in an era when the geographically oriented epidemiologist strives for tissue confirmation of the primary site of tumors, we find that in as sophisticated a country as Poland, only 50% of deaths are certified by a physician. One can only guess the value of national statistics from one of the newly emerging countries. And it is interesting to know that there is a mouse strain with a naturally acquired disease with this sequence:

*continued page 234*

# PLAN TO ATTEND
# The
# 111th ANNUAL MEETING
## to be held at
## The Princess Kaiulani Hotel
## May 17 - 20, 1967

The Guest Speakers Will Discuss

## "Genetics & Heredity In Today's Practice"

*Guest Speakers are:*

Charles L. Hudson, M.D.
Howard W. Jones, Jr., M.D.
Georgianna Segar Jones, M.D.
David W. Smith, M.D.
Virginia Apgar, M.D.
Oscar Auerbach, M.D.

This scientific gathering will culminate with the Annual Banquet for all the doctors and their guests at the Pacific Ballroom - Ilikai Hotel

No registration fee for Hawaii Medical Association members.





Posed by professional model.

# You can't set her free. But you can help her feel less anxious.

You know this woman.

She's anxious, tense, irritable. She's felt this way for months.

Beset by the seemingly insurmountable problems of raising a young family, and confined to the home most of the time, her symptoms reflect a sense of inadequacy and isolation. Your reassurance and guidance may have helped some, but not enough.

SERAX (oxazepam) cannot change her environment, of course. But it can help relieve anxiety, tension, agitation and irritability, thus strengthening her ability to cope with day-to-day problems. Eventually—as she regains confidence and composure—your counsel may be all the support she needs.

Indicated in anxiety, tension, agitation, irritability, and anxiety associated with depression.

May be used in a broad range of patients, generally with considerable dosage flexibility.

**Contraindications:** History of previous hypersensitivity to oxazepam. Oxazepam is not indicated in psychoses.

**Precautions:** Hypotensive reactions are rare, but use with caution where complications could ensue from a fall in blood pressure, especially in the elderly. One patient exhibiting drug dependency by taking a chronic overdose developed upon cessation questionable withdrawal symptoms. Carefully supervise dose and amounts prescribed, especially for patients prone to overdose; excessive prolonged use in susceptible patients (alcoholics, ex-addicts, etc.) may result in dependence or habituation. Reduce dosage gradually after prolonged excessive dosage to avoid possible epileptiform seizures. Caution patients against driving or operating machinery until absence of drowsiness or dizziness is ascertained. Warn patients of possible reduction in alcohol tolerance. Safety for use in pregnancy has not been established.

Not indicated in children under 6 years; absolute dosage for 6 to 12 year-olds not established.

**Side Effects:** Therapy-interrupting side effects are rare. Transient mild drowsiness is common initially; if persistent, reduce dosage. Dizziness, vertigo and headache have also occurred infrequently; syncope, rarely. Mild paradoxical reactions (excitement, stimulation of affect) are reported in psychiatric patients. Minor diffuse rashes (morbilliform, urticarial and maculopapular) are rare. Nausea, lethargy, edema, slurred speech, tremor and altered libido are rare and generally controllable by dosage reduction. Although rare, leukopenia and hepatic dysfunction including jaundice have been reported during therapy. Periodic blood counts and liver function tests are advised. Ataxia, reported rarely, does not appear related to dose or age.

These side reactions, noted with related compounds, are not yet reported: paradoxical excitation with severe rage reactions, hallucinations, menstrual irregularities, change in EEG pattern, blood dyscrasias (including agranulocytosis), blurred vision, diplopia, incontinence, stupor, disorientation, fever, euphoria and dysmetria.

**Availability:** Capsules of 10, 15 and 30 mg. oxazepam.

To help you relieve anxiety and tension

## Serax® (oxazepam)

Wyeth® SERVICE TO MEDICINE

Wyeth Laboratories
Philadelphia, Pa.

# HAWAII TECHNOLOGISTS' BULLETIN

*Official Publication of the Hawaii Society of Medical Technologists*

*Editor:* LOUISE WULFF, MT(ASCP), University of Hawaii

## *Automation and the Technologist—Where Are We Going?*

The patient is scheduled for surgery and, in the admitting office the evening before, while the papers necessary for his admission are being prepared, a data card with all of his identification is registered in a computer and begins a process which, twenty years ago, was unthinkable both to him and his physician. From the central computer, and not a large computer at that, a series of orders are generated which enroll him, assign him, sample him, feed him, test him, prep him, and ready him for his turn in the cool green sheets beneath the cold blue light—NPO after midnight and drowsy.

All forces in the hospital are alerted both by his physician's orders and by the memory of the computer which sends out all standing orders on such a presurgical case. A typewriter in the laboratory writes the order to sample the patient's blood and urine and specimen labels, by number, and all required result cards are issued from another printer in admitting and await the technician at the nursing station.

From a much smaller sample than any we could have afforded to draw in the past, a single or group of continuously running analyzers perform tests for glucose, urea nitrogen, creatinine, sodium, potassium, chloride, $CO_2$, total protein, albumin, calcium, phosphate, bilirubin, alkalin phosphatase, SGOT, and amylase. Autodilutors, electronic counters, and colorimeters allow the CBC to be completed while the technologist performs the differential count. Sophisticated laboratories will do both blood typing and routine serology for syphilis automatically, and access to the computer permits a rapid survey of blood stores for transfusion and available donors.

Within the hour of sampling, the laboratory has automatically calculated all values and the computer has examined them all in terms of calculations of the normal, the spread, and the "impossible" for each individual test, returning the impossible or improbable result to the technologist for investigation. All values are assembled in the computer and printed by the remote typewriter on the nursing unit. If desired, all previous laboratory data for the patient are printed at the same time, or perhaps only a summary of all prothrombin times or glucose levels, if drug dosage needs adjustment. If "impossible" potassium levels suggest the need, for example, the technologist may request the computer for a statistical analysis of all potassium levels for the past 24 hours as a check on the procedure, or he may also ask for all previous potassiums on the patient with the "impossible" results.

## *Automation—Threat or Promise?*

Like much of the progress in the present century, even while the possibility of change is being considered by those whose work is affected by it, the change is realized, unplanned for and confusing. Automation is progress, it need not spell "pau" for the Medical Technologist.

When, some years back, every diesel-powered railroad engine carried a fireman in the cabin—a fireman most essential to the running of a steam engine but absolutely functionless to a diesel—observers of this economic waste often asked why the railroads did not retrain their men. The answer, for the majority, was that the firemen did not *want* to be retrained. (In all fairness, some men were too old to begin something new and many others lacked the educational background and skills needed for diesel operation.) A powerful union upheld their "right" to work only as they had been trained and originally hired.

The changing techniques in clinical laboratories and the advances in railroading are not exactly analogous, but certainly the change in the laboratories is no more rapid than that in railroading, and a lesson is there—and it is not suggested that what Medical Technologists need is a powerful union! Just what is the problem and what must be done, on the job, and in training? Is there a place for trained personnel somewhere between a biophysicist, biochemist, and a general flunky?

For the next few issues we will consider the "shape of things to come," taking a cold, hard look at what is already here, and try to arrive at what automation may bring to us and what we must bring to it. In this issue Dr. Drake Will considers the problem in its total aspect. In issues to come there will be reports on automation in departments other than chemistry, future uses of automation as seen by the manufacturers of the equipment, differences in the types of equipment, changes in educational requirements, etc. If these articles move you to comment or question, send your ideas to the editor; this is the concern of all of us.

All essential work has taken about one hour and an analyzable record, accessible to all concerned, has been created in a data file whose magnitude is truly incomprehensible to most of us and whose potential for analysis awaits only the properly phrased question. The system has the capability, in this writer's opinion, to revolutionize the strictly *analytical* aspects of medical science but automated equipment and electronic data processing do not and never conceivably will replace the many highly trained *people* who now and in the future minister to the sick.

A change in observation and philosophy is required when we consider the implications and true place in the laboratory of automated and electronic systems—and that is not so simple. The remote-line typewriter rattling by itself in the laboratory is noisy and upsetting but is simply the computer's only means of communicating its requested analysis or message. The automatic analyzer, regardless of its size or cost, is only accurately performing and accurately recording data from the dozen to three dozen tests which now are high in daily (and nightly) laboratory volume. The good technologist has wished for some time that these tests were automated so that he or she could be free to work in the steroid laboratory or on a modification of the VMA procedure. Who would wish to return to the days of urinalysis without dipsticks? Or to the time—so shortly past—before electronic blood cell counters? While we can jokingly imagine a urinalysis dipstick three feet long which would record everything but the patient's basic personality pattern on its colored squares, we would not wish to see research stopped in the attempt to accomplish just this very feat.

The danger posed to us by this evolving marriage of automated and electronic laboratory equipment and computers is not that we shall be displaced or unessential, but the danger of our not being ready and willing to move forward in our own field as fast as it is itself moving on the frontiers of medical science. A humdrum day counting trillions of erythrocytes, or looking at the flame in the mirror to see if it is still burning, is being replaced, within the working years of most of us, by machines to do the humdrum, and time to test and master some of the fifty per cent of our work which we must now reluctantly send to others, or the new procedures which will be added to our lists in the next ten years. This impelling thrust out of the humdrum of technology is the reason for the lengthening and improvement of university training programs, rising standards in registry and licensure requirements, postgraduate programs in laboratory technology. The technologist worthy of his field will not be replaced by automated laboratory equipment. The truth of this requires only a very cursory analysis of the changes and growth in the last ten years in his profession and an educated prediction of the next ten years. The automation of approximately one-tenth of the total work of the laboratory and the ability to use computers for information storage and analysis is a natural progression in laboratory science. Clinical laboratory technology has one of the most exciting futures in medical science.

DRAKE W. WILL, M.D.
*Chief of Pathology*
*The Queen's Hospital*

## *New at U.H.*

The University is particularly fortunate in the newest addition to the staff of the Medical Technology Division, Miss Patricia Taylor MT (ASCP), who comes to Hawaii from Los Angeles where she was Supervisor of the Blood Bank at U.C.L.A. Medical Center. She was also teaching supervisor of the School of Medical Technology at the Center. She took her undergraduate work at Indiana University following which she worked in a small hospital doing general laboratory work.



Besides working on a research project with Dr. Hokama in the University's newly formed Department of Pathology, Pat is teaching a course in Immunohematology this semester. She is transferring her membership to the Hawaii Society from C.S.M.T. where she was Chairman of their Research Committee.

Pat is interested in music and travel—we hope Hawaii will provide plenty of both?

ileocecal ulceration, cecal myeloma, disseminated myeloma. The development of animal tumors is studied to determine the relationship of polyps to invasive intestinal cancers. An informal discussion by the contributors summarizes the points of interest and conflict.

GRANT N. STEMMERMANN, M.D.

### ★Current Therapy 1966, 18th Ed.

*Edited by Howard F. Conn, M.D., 857 pp., $13.00, W. B. Saunders, 1966.*

THERE ARE 317 contributors to this eighteenth edition of what has become an annual classic. Its 857 pages are divided into 16 sections consisting of either groups of diseases (infectious diseases, allergic diseases, etc.) or body systems (respiratory, nervous, etc.). The sections are further divided into chapters of individual or closely related diseases.

Not all chapters are directly concerned with specific diseases: E.g., there are chapters on immunization, feeding of the normal infant, and fluid and electrolyte therapy. All told there are 288 individual headings. It is to the credit of the editor that there appears to be practically no overlap. Another feature that makes this book unusual in the field of texts on treatment is that the present edition is not merely a revision of previous texts. This is assured by rotating topics among authors each year. This provides readers with access to the treatment methods of various recognized authorities.

*Current Therapy* sincerely attempts and often manages to keep up to date with the rapidly changing medical scene. It is highly recommended for any clinician, but in particular for the generalist.

FREDERICK A. DODGE, M.D.

### Rocky Mountain Spotted Fever

*By Jerry K. Aikawa, M.D., 140 pp., $7.50, Charles C. Thomas, 1966.*

THIS MONOGRAPH will be of value to students and clinicians alike as a source of insight into the fascinating history of Rocky Mountain spotted fever. It briefly chronicles the story, from the initial suspicions of two young pathologists, Louis B. Wilson and W. M. Chowning, through brilliant contributions of Howard T. Ricketts, down to the final control of this uniquely American disease. The author has made abundant use of source documents and the still fresh memories of those who knew first hand the anguish and triumphs of this segment of medical history.

RICHARD R. KELLEY, M.D.

### ★Pathology Annual, Vol. I

*Series editor Sheldon C. Sommers, M.D., 387 pp., $12.00, Appleton-Century-Crofts, 1966.*

THIS IS THE FIRST in a projected series of yearly collections of essays by pathologists on subjects which particularly interest them. As evidenced by this first edition, the subjects covered will be broad and varied. The information is comprehensive but not exhaustive, and is presented in a very understandable and readable fashion. The bibliographies at the end of each chapter appear to be excellent. The black and white photographs used throughout are of very good quality. Although primarily published for pathologists, these essays are of value and interest to all physicians, especially the essays which pertain to the physician's specialty.

ANN B. CATTS, M.D.

### ★Retinal Diseases: Symposium on differential diagnostic problems of posterior uveitis

*Edited by Samuel J. Kimura, M.D., and Wayne M. Caygill, M.D., 395 pp., $12.50, Lea & Febiger, 1966.*

TO THE OPHTHALMOLOGIST interested in retinal diseases who has not had the opportunity personally to attend such a symposium, this book is a must. It is a beautiful attempt to correlate clinical and pathological concepts, in conjunction with recent therapeutic efforts for management of various retinal conditions.

The presentation is in the order in which the symposium was held. Under the discussion of each condition, the comments of the various participants give one the feeling of being in the audience. The discussions of the clinical and pathological characteristics are so exacting, it borders on "retinal splitting." Probably few other branches of medicine stretch their clinical knowledge to the electron microscopic level as is done in ophthalmology. This book makes one appreciate this fact.

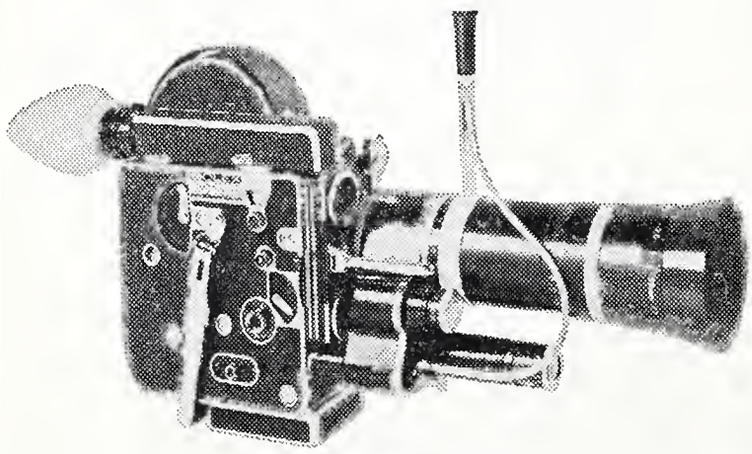
WAYNE WONG, M.D.

### The Heart and Circulation: Research, Vol. I

*Second National Conference on Cardiovascular Diseases, Edited by E. Cowles Andrus, Associate editor Cyrus H. Maxwell, 684 pp., U.S. Government Printing office, Washington, D.C., 1964.*

VOLUME I is a summary of the Second National Conference on Cardiovascular Disease held in 1964. An extensive volume, it describes the progress made in this field since the First National Conference held in 1950. It includes summaries of various phases of research and clinical development in this broad subject, with a complete

*continued page 238*



The perfect 16mm movie camera for medical photography, the BOLEX H-16 REX-4 camera with 86EE 18 to 86mm zoom lens. Variable shutter speeds from 12 to 64 frames per second. Complete outfit $1028.00. Come in for free demonstration today.

**Bolex Headquarters**

**HAWAII CAMERA**

1415 KAPIOLANI BOULEVARD, HONOLULU, HAWAII 96814

**Phone 995-321**

# collect+add+centrifuge+ prepare+centrifuge+wash+ centrifuge+decant+precipitate+ disperse+let stand+stir+ centrifuge+filter+dilute+ adjust pH+warm+centrifuge+ reconstitute+adjust pH+shake

**getting tired?** All these operations are needed in the prothrombin-proconvertin (P & P) test, to prepare prothrombin-free beef plasma.* All of them can be avoided with Simplastin-A. Developed by the Coagulation Research Laboratory at Warner-Lambert Researeh Institute, Simplastin-A is a thromboplastin-ealcium with Factor V and fibrinogen added. It eliminates the need for prothrombin-free beef plasma. And it remains stable *after* reconstitution for one working day, if recapped and refrigerated. With the aid of Simplastin-A the P & P test becomes feasible for most laboratories, because it ean now be performed with commereially available, standardized reagents, and in minimum time.

*Ware, A. G., and Stragnell, R.: Am. J. Clin. Path. *22*:791, 1952.

**Simplastin®-A**

*your "all-in-one" reagent for P & P testing*

GENERAL DIAGNOSTICS Division Warner-Chilcott Laboratories, Morris Plains, N.J.

# THREE TIMES A YEAR

*Your patients without a plan to economically protect them when they are in need of medical assistance may join Hawaii's own community service medical plan on an individual basis three times a year.*

*Membership is open to qualified individuals of all ages in*

MARCH — JULY — *and* — NOVEMBER

*HMSA is a non-profit, community service organization. As such it is able to provide tremendous benefits for reasonably low dues.*

*HMSA is the medical plan which gives you free choice of doctors and hospitals — an extremely desirable feature.*

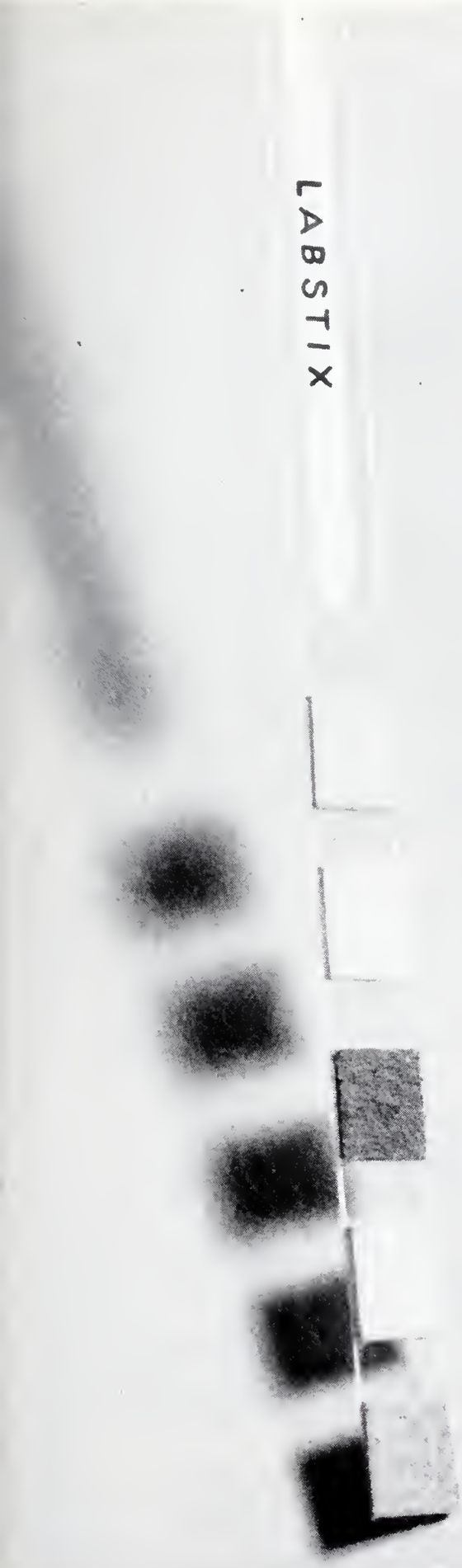
Member of Western Conference of Prepaid Medical Service Plans

HMSA ®

BLUE SHIELD PLAN FOR HAWAII

## HAWAII MEDICAL SERVICE ASSOCIATION

*For More than 28 Years — Hawaii's Own / Hawaii Owned*




# new from Ames
# 5 basic uro-analytical facts in 30 seconds

# Labstix®

BRAND REAGENT STRIPS

### ...broadest urine screening possible from a single reagent strip

Urine test results with LABSTIX Reagent Strips can represent significant guides to differential diagnosis or therapy in many conditions. An unexpected "positive" may enable you to detect hidden pathology—long before more recognizable symptoms become evident. Negative results, which permit you to rule out abnormalities in a broad clinical range, can serve as baseline values for reference in future examinations. The 5 colorimetric test areas encompassed on LABSTIX Reagent Strips are:

**pH**—values are read numerically in the essential range of pH 5 to pH 9.

**Protein**—results are read either in the "plus" system or in mg. % in amounts approximating "trace," 30, 100, 300, and over 1000 mg. %.

**Glucose**—provides a "Yes-or-No" answer for urine "sugar spill."

**Ketones**—detects ketone bodies in urine—**both** acetoacetic acid and acetone. Reacts with as little as 5 to 10 mg. % of acetoacetic acid.

**Occult Blood**—specific test for intact red cells, hemoglobin or myoglobin. Results are read as negative, small, moderate or large amounts.

### Now a Clear Reagent Strip of Firm Construction

**...facilitates handling during testing procedure. Excellent color contrast made possible by the clear plastic strip, together with the clearly defined color charts provided, permits precise, reproducible colorimetric readings in all 5 test areas. A more definitive interpretation of uro-analytical facts is made possible.**

Available: LABSTIX Reagent Strips, bottles of 100 (color charts are supplied with each bottle).

179R66

Ames Company
Division Miles Laboratories, Inc.
Elkhart, Indiana, U.S.A.

Ames

bibliography at the end of each section. Conclusions and recommendations made from the conference discussions are also included in the summary. This volume may serve as a handy reference for current status of some of the cardiovascular problems and identify the areas of needs and research.

### The Treatment of Renal Failure: Therapeutic Principles in the Management of Acute and Chronic Uremia, 2d Ed.

*By John P. Merrill, M.D., 387 pp., $12.75, Grune & Stratton, 1965.*

THIS THOROUGH and comprehensive discussion of normal and abnormal renal functions, and their relation to disease states, is very clear. Dr. Merrill's outline of the principles involved in the management of acute and chronic renal failure is excellent. In addition, the second edition has added a more detailed section on the use of chronic hemodialysis in the treatment of terminal renal disease, as well as a section on renal transplantation.

A very useful book for the internist.

DUDLEY SETO, M.D.

### Psychopathology of Schizophrenia

*Edited by Paul H. Hoch, M.D., and Joseph Zubin, Ph.D., 582 pp., $19.75, Grune & Stratton, 1966.*

THIS BOOK CONTAINS what I consider to be an advanced form of an unfortunate trend in modern editing. It contains a number of excellent chapters by workers in the field of psychiatry well known to me. Most of the book, however, contains research papers that seem to have no place in a text. These papers, some by well-known authors and others by authors unfamiliar to me, are in many cases inconclusive or contain negative results. In my opinion, these papers are of value only to someone doing clinical research in schizophrenia and could be of much greater value if they had been presented in an edited or résumé form. I therefore found this book to be of only limited value to the clinician, and though it will be a valuable addition to a large library, I would not recommend that anyone purchase the book without first reviewing the library copy.

EDWIN P. GRAMLICH, M.D.

### ★Fundamentals of Clinical Hematology, 2d Ed.

*By Byrd S. Leavell, M.D. and Oscar A. Thorup, Jr., M.D., 597 pp., $12.50, W. B. Saunders Company, 1966.*

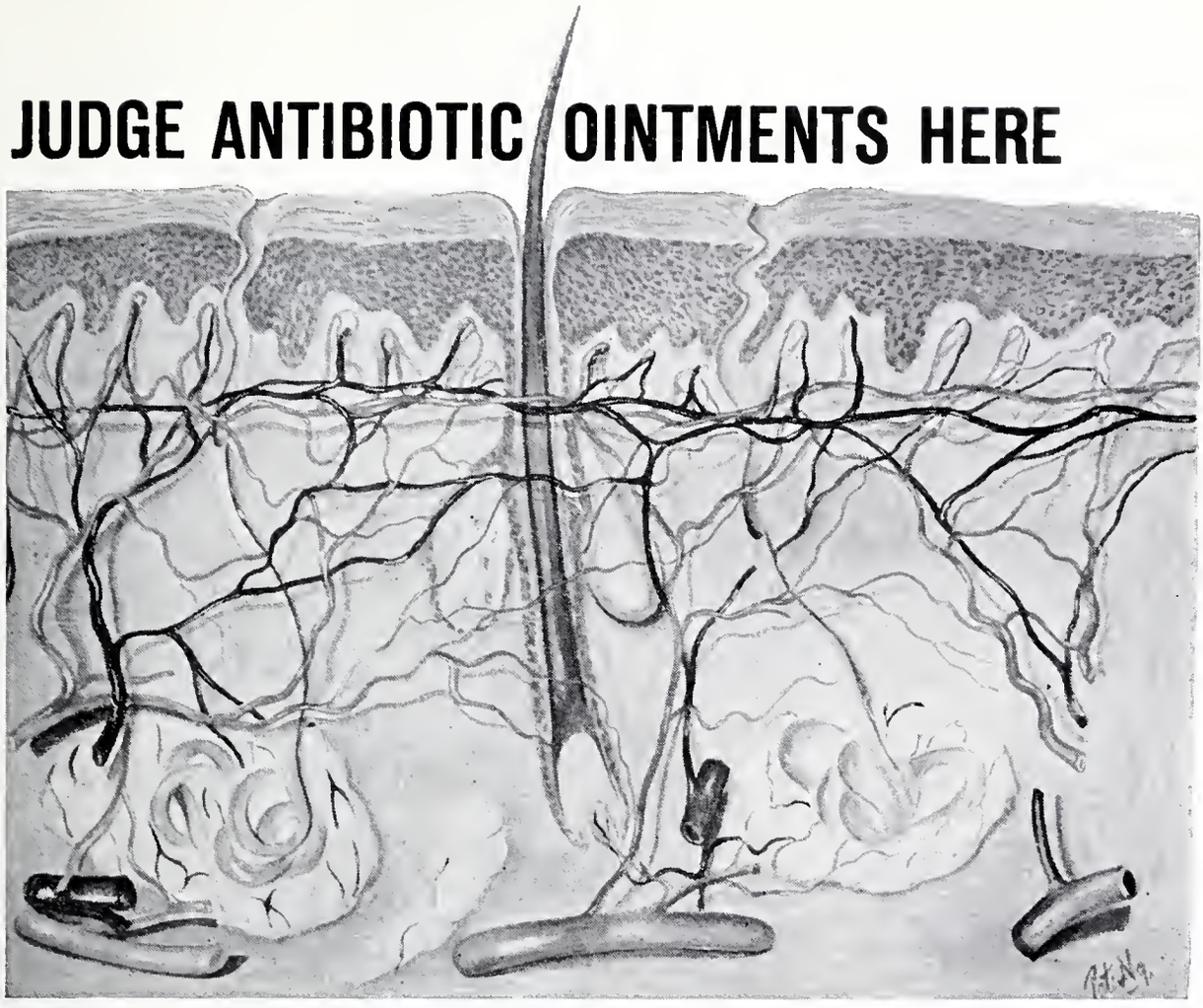
MOST AUTHORS who set out to reduce a field as large and complex as hematology into a concise, comprehensive, and readable volume fall short by being either too concise, too comprehensive, or unreadable. However, Doctors Leavell and Thorup have been eminently successful in achieving their goals in this second edition of their work.

This book was originally meant to be a text for medical students, but because of the currency of the material and its clinical approach to hematologic problems, the physician in practice will find it a practical reference book for his office shelf. He will find himself consulting repeatedly such chapters as "Diagnosis of the Patient

*continued page 240*



# JUDGE ANTIBIOTIC OINTMENTS HERE



## Results on skin are final proof of any topical antibiotic's effectiveness

**No in vitro test can duplicate a clinical situation on living skin.** 'Neosporin' (polymyxin B—bacitracin—neomycin) Ointment has consistently proven its effectiveness in thousands of cases of bacterial skin infection. The spectra of the three antibiotics overlap in such a way as to provide bactericidal action against most pathogenic bacteria likely to be found topically. Diffusion of the antibiotics from the special petrolatum base is rapid since they are insoluble in the petrolatum, but readily soluble in tissue fluids. The Ointment is bland and nonirritating.

**Caution:** As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

**Contraindications:** This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

**Supplied:** Tubes of 1 oz., ½ oz. with applicator tip, and ⅛ oz. with ophthalmic tip.

Complete literature available on request from Professional Services Dept. PML.

# 'NEOSPORIN'®
brand

## POLYMYXIN B-BACITRACIN-NEOMYCIN OINTMENT

**BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.**

ELECTRONIC BILLING!
• FAST • EFFICIENT • ECONOMICAL • ACCURATE
• A STATEMENT WITH A PROFESSIONAL APPEARANCE DESIGNED FOR PROFESSIONAL PEOPLE WITH DISCRIMINATING TASTE.
• A BILLING SYSTEM BACKED BY OVER 12 YEARS OF *PROVEN DEPENDABLE* SERVICE BY A NATIONALLY RECOGNIZED FIRM.

Financial Management Institute
Management Methods For Professional People
1481 S. King Street Honolulu, Hawaii 96814
Phone 994-989

## *Book Reviews* *continued from 238*

with Anemia," "Examination of the Patient with Hemorrhagic Diathesis," and "The Diagnosis of the Patient with Enlarged Lymph Nodes." In addition, all topics covered are liberally supplied with references, so that this book could advisedly be used as a springboard to more detailed treatment of clinical problems.

REGINALD C. S. HO, M.D.

### ★Current Pediatric Therapy (1966-1967)

*By Sydney S. Gellis, M.D., and Benjamin M. Kagan, M.D., 956 pp., $17.50, W. B. Saunders Company, 1966.*

THIS IS ANOTHER concise, revised, all-inclusive reference text on the treatment of pediatric problems. The sections are divided into different anatomical systems with multiple authorship.

It is recommended to all interested in the care and welfare of infants and children.

REYNOLD S. SHIRAI, M.D.

## Also Received

### ☆Your Wonderful Baby: A Practical Approach to Baby and Child Care

*By Willis J. Potts, M.D., 312 pp., $4.95, Rand McNally & Company, 1966.*

THIS TEXT on child care can be recommended highly to the expectant mother. The author is renowned as a pediatric surgeon, but this text shows him for the true pediatrician he is.

### ★Examination of the Urine: A Programmed Text, Pt. I & Pt. III

*By John M. Weller, M.D., and James A. Greene, Jr., M.D., 135 pp., $8.50, Appleton-Century-Crofts, 1966.*

ALTHOUGH WRITTEN for the medical student, this excellent programmed text with photomicrographs appears to be of value as a review of the diagnostic value of good urine evaluation.

### The Cat: Facts About Fantasy

*By Mary R. Haworth, Ph.D., 322 pp., $9.75, Grune & Stratton, 1966.*

AN APPRAISAL of the Children's Apperception Test used by clinical psychologists.

### Mathematics in Medicine and the Sciences

*By George R. Stibitz, M.D., 391 pp., $12.50, Year Book Medical Publishers, 1966.*

THIS TEXT is an excellent source of methods in which mathematics can aid in the biological sciences. It is written for those with a good mathematical background and provides one with the background for "computer" medicine.

### Basic Physiology and Anatomy

*By Norman Burke Taylor, M.D., in collaboration with Margaret McPhedran, R.N., M.A., 648 pp., $6.95, Putnam's Sons, 1965.*

CLEARLY illustrated text for use in nursing education.

*continued page 242*

WILLIAMS MORTUARY
"CHAPEL OF THE CHIMES"
1076 S. Beretania St., Phone 52-587 Ample Parking Adjoining Mortuary
OVER A CENTURY OF SERVICE
*"Service measured not by gold but by the Golden Rule"*
MEMBER
National Selected Morticians, National Funeral Directors Association, Order of the Golden Rule, Hawaii Funeral Directors Association

# What a difference a good night's sleep makes



A good night's sleep and all's well with the world. A night of sleepless tossing and the day's pleasant moments lose their luster, routine tasks seem like grinding drudgery.

Count on Doriden to help make the difference. For most patients with insomnia, it provides a good night's sleep, a clear awakening.

# Doriden® (glutethimide CIBA)

**Doriden®** (glutethimide CIBA)

**Indications and Dosage:** *Insomnia*—0.5 Gm at bedtime. *Preoperative Sedation*—0.5 Gm the night before surgery; 0.5 to 1 Gm 1 hour before anesthesia. *Obstetric Sedation*—0.5 Gm at onset of labor.

Continuing total daily dosage over 1 Gm is not recommended.

**Caution:** Supervise dosage carefully, especially in patients with a known propensity for overdosing. Excessive and prolonged use in susceptible persons (e.g., alcoholics, former addicts, severe psychoneurotics) may result in dependence and withdrawal reactions. In those cases, reduce dosage gradually to lessen the likelihood of withdrawal reactions such as nausea, abdominal discomfort, tremors, or convulsions. Newborns of mothers dependent on glutethimide may exhibit withdrawal symptoms.

**Side Effects:** Occasionally, a skin rash may occur; if so, withdraw drug. The rash usually clears spontaneously in 2 or 3 days. Occasionally nausea also occurs. Rarely, acute hypersensitivity reactions and blood dyscrasias have been associated with glutethimide therapy.

**Supplied:** *Tablets*, 0.5 Gm (white, scored) and 0.25 Gm (white, scored); bottles of 100, 500 and 1000. *Tablets*, 0.125 Gm (white); bottles of 100. *Capsules*, 0.5 Gm (blue and white); bottles of 100.

*Consult complete literature before prescribing.* 2/3646 MBL

CIBA Pharmaceutical Company, Summit, N.J. CIBA

*Book Reviews* continued from 240

### Text-Aid for Basic Physiology and Anatomy

*By Richard H. Miller, R.N., B.S., 182 pp., $4.95, 1965.*

A PROGRAMMED WORKBOOK to evaluate individual progress for the accompanying textbook.

### Man and Africa, a Ciba Foundation Symposium

*Edited by Gordon Wolstenholme and Maeve O'Connor, 400 pp., $7.50, Little, Brown and Company, 1965.*

A COMPREHENSIVE nonmedical symposium on Africa in the usual excellent Ciba Foundation format.

### Rare Diseases in Internal Medicine

*By Neuton S. Stern, A.B., M.D., F.A.C.P., 572 pp., $18.50, Charles C. Thomas, 1966.*

SELECTED SUMMARIES of unusual observations reported in six major internal medicine journals over the past 13 years are compiled. It proves to be interesting reading and may be of value for the physician interested in the rare case.

### ★Principles of Pathology, 2d Ed.

*By Howard C. Hopps, M.D., 403 pp., $8.95, Appleton-Century-Crofts, 1964.*

ALTHOUGH WRITTEN for the medical student, this simplified text on the principles of pathology appears to be invaluable for the physician who would want to review basic pathologic principles.

### Prognosis: A Guide to the Study and Practice of Clinical Medicine

*By Leslie A. Osborn, M.D., 286 pp., $10.00, Charles C. Thomas, 1966.*

THIS TEXT was written for the medical student with emphasis on prognosis rather than merely diagnosis as the goal of the practicing physician.

### Introduction to the Clinical Laboratory, 2d Ed.

*By Robert P. MacFate, Ch.E., M.S., Ph.D., 591 pp., $11.50, Year Book Medical Publishers, 1966.*

A BASIC TEXT for medical technologists.

### ★The Heart: Its Function in Health and Disease

*By Arthur Selzer, M.D., 301 pp., $5.95, University of California Press, 1966.*

THIS EXCELLENT TEXT can be highly recommended for your cardiac patient. It is written in lay terms by one of the outstanding cardiologists of today.

### Community Mental Health Services in Northern Europe

*By Sylvan S. Furman, 215 pp., $1.75, U.S. Dept. of Health, Education, and Welfare, 1965.*

A REPORT on observations of mental health services in Great Britain, Netherlands, Denmark, and Sweden. ■

WHEN YOU HAVE
A CALL TO MAKE
...CALL HAWAIIAN AIRLINES
FOR CONVENIENT JET FLIGHTS
TO ALL ISLANDS
WHETHER FOR
BUSINESS OR PLEASURE

FOR RESERVATIONS CALL:

| HONOLULU | KAHULUI | LANAI |
|---|---|---|
| 817-611 | 75-011 | 3-222 |
| HANA | KAMUELA | LIHUE |
| 442-483 | 858-505 | 2-751 |
| HILO | KONA | MOLOKAI |
| 50-811 | 256-465 | 37-475 |

HAWAIIAN AIRLINES
Holder of the World's Safety Record



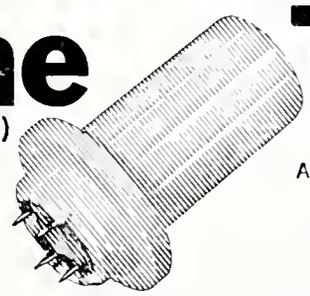
# what time is it?

For the past
two years
there's been
one new case
of active tuberculosis
reported for every
four thousand
of U.S. population.

# it's time to tine.

## Tuberculin, Tine Test

(Rosenthal) Lederle



Available in 5's and 25's.
Order now
from your pharmacist
or your Lederle
representative.

LEDERLE LABORATORIES, A Division of American Cyanamid Company, Pearl River, New York

414-6—4046R

# LET LANIOLU ASSIST YOU IN THE CARE OF YOUR GERIATRIC PATIENT

## FOR THE PATIENTS WHO SHOULD NOT LIVE ALONE

APARTMENT LIVING—for those still able to carry on outside daily activities

## FOR THE PATIENT UNABLE TO LIVE ALONE

- SPECIAL CARE—Apartment living with special assistance in self care activities.
- NURSING & CONVALESCENT—Complete infirmary facility under the 24-hour supervision of R.N.'s providing intensive care for the chronically ill.
- EXTENDED CARE for Medicare. Certified to provide all the posthospital extended care provided under the Health Insurance for the Aged Program.

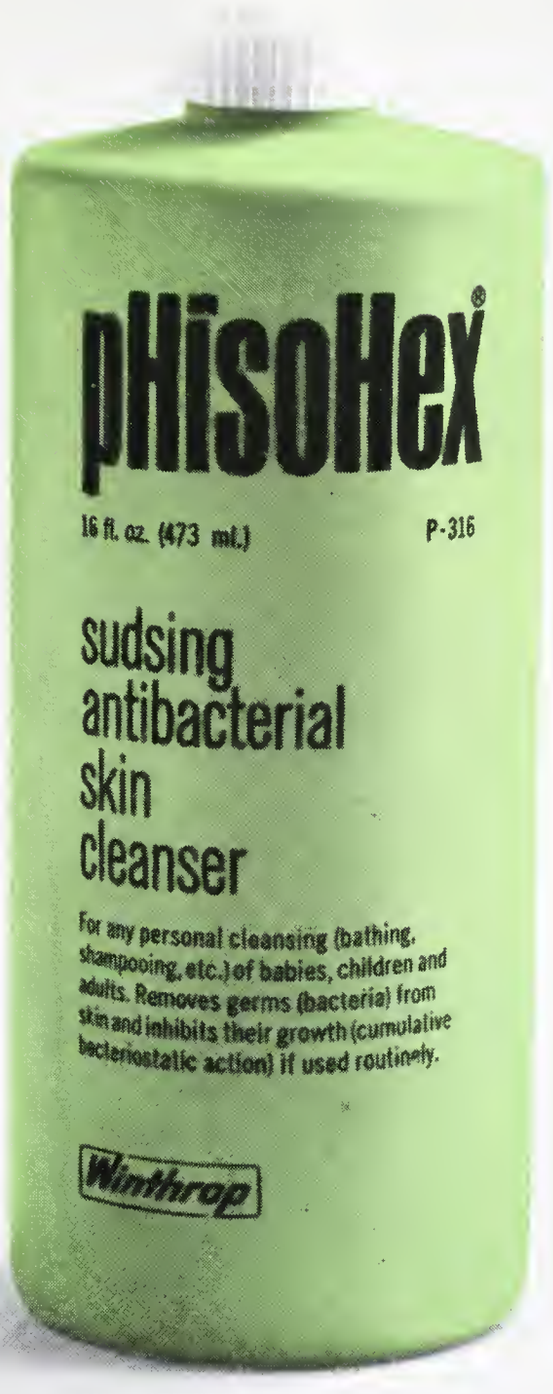
## Available to all Residents

Occupational Therapist—to assist physicians in evaluating patient's level of function and guiding therapeutic activities.

Dietary Consultant—to assure the special diets to meet all needs.

Social Services—Trained social worker to assist with social and emotional problems.

RONALD R. RAMSTEAD, *Administrator*
333 Lewers Street • Telephone: 937-644




# No Soap

pHisoHex is not a soap. It's a specially designed antibacterial detergent with the same acidic reaction as skin—pH 5.5.

The detergent component of pHisoHex—entsufon—is more surface active than soap. It enables pHisoHex to emulsify oils, peptize and disperse soils, cleanse the orifices of the sebaceous glands, sweat glands and hair follicles (areas heavily contaminated with bacteria) rapidly, thoroughly, atraumatically. The special emollient base is the most effective vehicle for transfer of hexachlorophene to the skin. (pHisoHex contains 3% hexachlorophene—more than could be embodied in a liquid soap.)

Unlike soap pHisoHex does not release alkali while it cleanses, does not interfere with the natural "acid mantle" of the skin. Instead it deposits an emollient film on the skin that acts as a substitute for sebum removed in the cleansing process. Hypoallergenic and "kind" to skin, pHisoHex has an unsurpassed record of tolerance among millions of users.

Are you one of them?

Supplied in unbreakable plastic squeeze bottles of 5 oz. and 16 oz. and in plastic bottles of 1 gallon.

Winthrop Winthrop Laboratories, New York, N.Y. 10016

ballot cast. Newly elected were Drs. Etta Best, President; Francis Wong, Vice President; Reginald Carvalho, Secretary; James Matayoshi, Treasurer; George Bracher, Board of Censors; Harold Lewis, HMA Delegate; and Nicholas Steuermann, HMA Alternate Delegate.

It was unanimously voted to back the Diabetes Detection Program. Dr. Okumoto brought up a request from the County Chairman for physicians to examine high school students unable to afford the required examinations for intramural sports. It was voted that these students be persuaded to go to their personal MD's and that the physicians would probably not charge for their examinations. The Library Committee's recommendations were unanimously accepted. It was announced that the "Christmas Carousel" group will hold a sale and that the proceeds will go towards the purchase of a cardiac monitor for the Hilo Hospital. The meeting concluded with a paper by Major Scragg of Tripler on "Diabetes in Pregnancy."

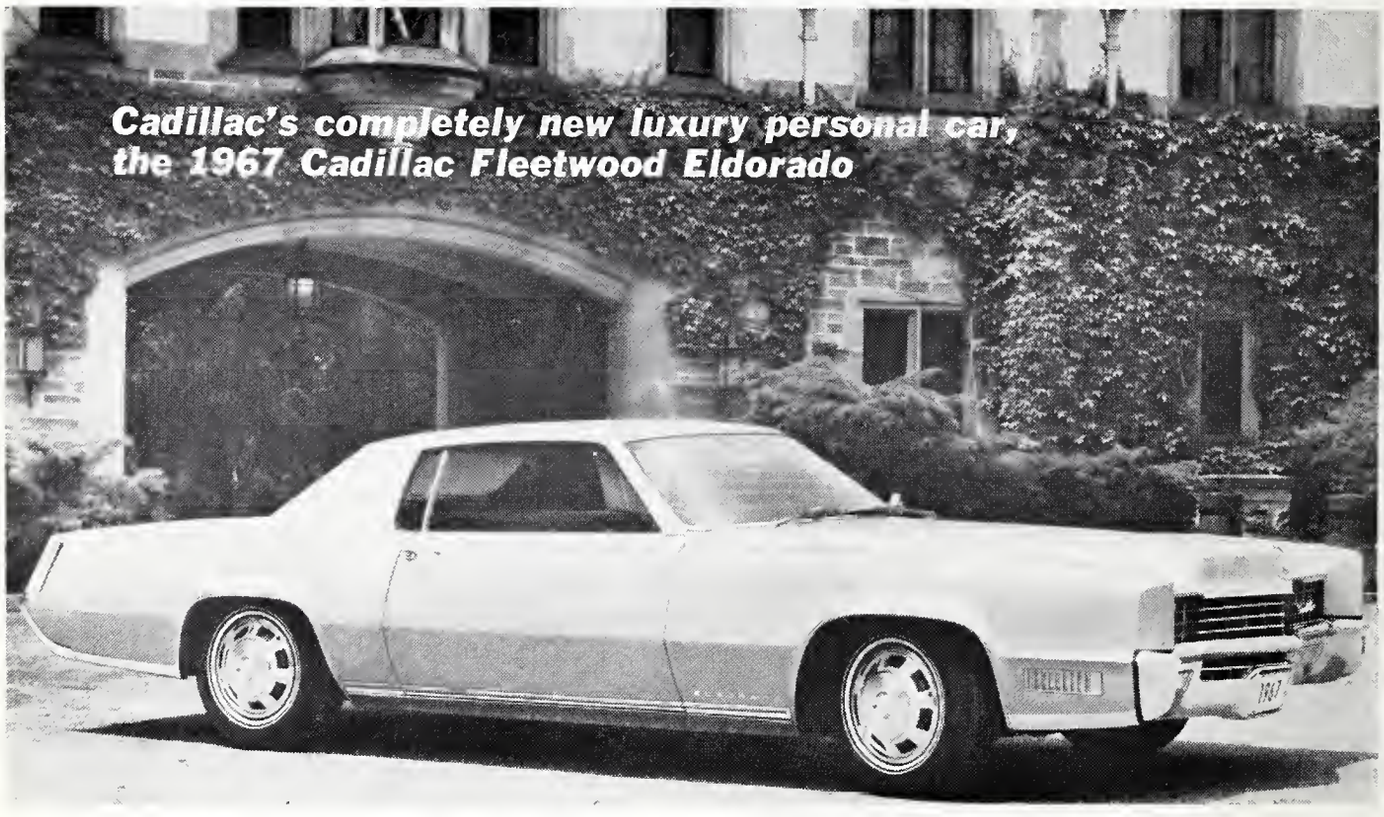
## Honolulu

Approximately 200 members were present at the October 4 meeting to welcome new members Juris Bergmanis, Takakazu Fukumura, Arthur Osako, James Stewart, Herbert Uemura, Walter Watt, and Norman Goldstein. Announcements included a search for doctors who play stringed instruments to join Dr. William Cody's combo, a request for sample drugs to be sent to Vietnam was made by Dr. Wilkinson, Dr. Arnold urged the membership to contribute to the Aloha United Fund Drive, Dr. Tomita reported that practically 100% financing had been guaranteed on the new Medical Plaza Building once the parking problem is solved, and doctors were urged to support the Foundation program by asking persons and groups interested in health insurance to contact the insurance companies who are selling the Foundation. The remainder of the program was devoted to honoring Dr. Harry L. Arnold, Jr., on the 25th Anniversary of the HAWAII MEDICAL JOURNAL. Guest speakers for the evening were Mr. George Chaplin, Editor of the *Honolulu Advertiser,* and Mr. A. A. Smyser, Editor of the *Honolulu Star-Bulletin.*

Approximately 190 members were present at the November 1 meeting to hear talks on "Party Issues" given by Mr. Edward E. Johnston, State Chairman of the Republican Party of Hawaii, and U. S. Senator Daniel K. Inouye. New members Drs. Victor Hay-Roe, Gordon C. Ontai, Hamilton M. Winston, Robert W. Davis, and Richard K. Blaisdell were welcomed into the Society. Announcements were made by the chairmen of the Postgraduate and Diabetes Committees. Dr. Harry Arnold, Jr., advised that the doctors' contributions to the Aloha United Fund Drive amounted to almost $20,000. Dr. William Wilkinson thanked the members for their help in collecting drug samples for Vietnam. Dr. Theodore Tomita urged doctors to attend the forthcoming Workmen's Compensation Bureau public hearing. The Nominating Committee's slate was opened for additional nominations. Nominated from the floor were Philip Arthur, Winfred Lee, Richard Mamiya, and Francis Oda for the vacancies on the Alternate Board of Governors; Elmer Johnson for the Medical Practice Committee; and Theodore Tomita for the Nominating Committee.

Approximately 200 members attended the annual meeting on December 6. New members Miguel Rivera and Lother M. Varady were introduced. Dr. Lowrey announced that there would be no raise in the County dues but that both the HMA and AMA dues for 1967 would

*continued page 248*




THE ONLY QUESTION THIS YEAR IS: WHICH CADILLAC?

*See all the exciting new Cadillac models at* **SCHUMAN'S**

*1234 South Beretania Street*



# George Washington told the truth (as usual)

"My manner of living is plain and I do not mean to be put out of it. A glass of wine and a bit of mutton are always ready, and such as are content to partake of that are always welcome."



**DEAR DOCTOR:**

George Washington told the truth (as usual) about cherry trees and wine. He liked wine, as you see above. He hoped his guests would like it, too. And his wife Martha (a famous cook —do you know her book?) liked it, too.

So we do not hesitate, Doctor, to recommend California wines in the diets of yourself and many of your patients. As you know, they provide antibacterial pigments, Vitamin B, amino acids, iron, sugars, polyphenols, and just plain pleasure. We believe that pleasure, for someone in your demanding profession, is very important. Here's to *your* pleasure and health, as well as that of your patients!

We'd like very much to send you (at the drop of a note on your letterhead) two most interesting free booklets: "WINE COOKERY—THE EASY WAY," which will make a kitten of your wife and a barbecue lion of yourself; and "USES OF WINE IN MEDICAL PRACTICE," newly revised, 64 pages, which summarizes a quarter of a century of scientific research on wine and its relation to your patients' well-being. We are quite sure you will find it useful.

Will you drop us a note? You'll receive both booklets free. Here's to your health again, Doctor, with wine!

*The Winemakers of California*

WINE ADVISORY BOARD, 717 MARKET ST., DEPT. 2, SAN FRANCISCO, CALIF. 94103

be increased. The members were urged to attend a public hearing on fluoridation on December 14. Dr. Lowrey reported that to the best of his knowledge there had been no change in the relationship status with HMSA. He announced that the annual reports had been circulated by mail. There being no questions or comments, it was voted that the annual reports be accepted as circulated. Mrs. O. D. Pinkerton, outgoing President of the Auxiliary, spoke briefly, and introduced the incoming President, Mrs. Varian Sloan. Dr. Lowrey thanked the Society for the privilege of serving during the year and urged the membership to read the annual reports. He was presented with a plaque by Dr. Mills in recognition of his leadership. The polls were closed at 8:00 P.M.

Dr. Richert, head teller, announced the election results as follows: *President-elect,* Keith F. O. Kuhlman; *Secretary,* Herbert Y. H. Chinn; *Treasurer,* K. S. Tom; *Board of Governors,* Ralph M. Beddow, James W. Cherry, Don E. Poulson, Coolidge S. Wakai; *Alternate Board of Governors,* Winfred Y. Lee, Richard T. Mamiya, John M. Ohtani; *Board of Censors,* John J. Lowrey; *Medical Practice Committee,* Thomas P. Frissell, Gordon Liu, Richard S. Omura; *Nominating Committee,* Chew Mung Lum, Theodore Tomita; *Delegates to HMA,* Don E. Poulson, Raymond M. Tamura, George H. Nip, Scott C. Brainard, Charles T. H. Ching, Gordon Liu, Winfred Y. Lee, Clarence S. Sakai, Walter S. Strode; *Alternate Delegates to HMA,* Victor M. Mori, Henry T. Oyama, Arno James Mundt, William H. Sage, Philip H. F. Watt, Charles Yamashiro, Dudley S. J. Seto, Edward L. S. Jim, Niall M. Scully, Jack S. Woodruff, Casimer Jasinski, Sorrell H. Waxman, Robert Kim, Richard K. B. Ho, Calvin C. J. Sia, Robert F. Bailey, Barton R. Becker, Walter F. Char, Ross Y. Hagino, Benjamin C. K. Tom, Max Botticelli, Raymond Fujikami, Edward Chesne, Frederick A. Dodge, Donald A. Jones.

Dr. O. D. Pinkerton officiated at the installation of the new President, Dr. George H. Mills, and the other officers. The meeting adjourned after a short talk by Dr. Mills on matters he felt would have a positive influence on the practice of medicine—the physician's responsibility in relation to Medicare; the Heart, Cancer, Stroke program. He cautioned the doctors about a rumored attempt of some hospitals to set up a select group of doctors to serve a captive group of Medicare patients, and told of the Foundation's losing a contract, despite lower cost and greater benefits.

## Kauai

A special meeting was held on July 12 to meet with a representative of the Aetna Casualty & Surety Co. to discuss the Part B provisions of the Medicare program. Of particular interest to KCMS was the role of the plantations and whether they will make a profit on physicians' services.

* * *

No meetings were held in August and September, except a dinner meeting on September 17 to honor AMA president, Dr. Hudson.

* * *

At the October 4 meeting the Diabetes Detection Drive scheduled for November 13 to 19 was announced. Dr. Kim advised that the expenses would be small and that there were sufficient funds in the savings account for this purpose. Correspondence was read relative to a review of contracts covering physicians' services on plantations and in hospitals. The opinion was expressed that the current arrangement for hospital-based physicians is necessary in order to maintain their services.

It was voted to invite the HMA president to the December meeting, place and time to be decided at the November meeting. The President advised that the HMA

*continued page 250*




These glasses are important to him—in his work, socially, and in terms of his physical well-being.

When's the last time you had an eye check? Schedule an appointment soon with your eye physician.

OBRIG Contact Lenses fitted by prescription. We are GUILD OPTICIANS, serving Hawaii since 1939.

GUILD OPTICIANS

**OPTICAL DISPENSERS**
**of Hawaii, Inc.**

| | |
|---|---|
| 1133 BISHOP ST. | 576-570 |
| 312 ALA MOANA BLDG. | 976-925 |
| PROFESSIONAL CENTER BLDG., KAILUA | 256-030 |

**Your stationery is a reflection of you... be certain the reflection is good!**

*star-bulletin printing company*

*the hallmark of fine printing in honolulu*

**SUPPLEMENT TO HAWAII MEDICAL JOURNAL**
**JANUARY-FEBRUARY 1967**

DOCTOR: For a constant reminder of medical meetings in the year 1967, place this where you and your secretary can see it.

## HOSPITALS

### Children's

Mondoy—12:30 p.m.—Weekly—Case Reports
Thursday—8:30 a.m.—Grond Rounds
Friday—12:30 p.m.—4th of each quarter beginning in January —Staff Luncheon and Meeting

### Kapiolani

Tuesday—12:30 p.m.—1st—Didoctic Conference
Tuesday—12:30 p.m.—2d—Jaurnal Club
Tuesday—12:30 p.m.—3d—Obs. Statistics
Tuesday—12:30 p.m.—4th—Gyn. Statistics
Thursdoy—12:30 p.m.—3d—Generol Staff Meeting
Fridoy—8:30 a.m.—Last—Infont Mortolity Conference
Saturday—7:30 a.m.—1st & 3d—Grand Rounds

### Kuakini

Everyday but Wednesday—8:00 o.m.—Medicol Rounds
Mondoy—1:00 p.m.—1st & 3d—X-ray Canference
Monday—1:00 p.m.—Last—Integrated Clinicol Pathologicol Conference
Manday—4:00 p.m.—Surgical Rounds
Tuesday—1:00 p.m.—1st—Medical Surgical GI Conference
Tuesday—1:00 p.m.—2d & 3d—General Medical Conference
Tuesday—1:00 p.m.—Last—Medicol Statistics Conference
Wednesday—8:30 a.m.—Weekly—Medical Chief Rounds
Wednesday—1:00 p.m.—2d & 4th—Journol Club
Wednesday—1:00 p.m.—3d—Gyn Statistics
Thursdoy—1:00 p.m.—2d—Gyn Canference
Thursday—1:00 p.m.—4th—Gyn Seminar
Friday—1:00 p.m.—Weekly—Surgical Conference
Friday—6:00 p.m.—2d—Quorterly Generol Staff Meetings

### Queen's

Monday—12:30 p.m.—Weekly—Ob-Gyn Stoff Conference
Mondoy—12:30 p.m.—3d—Uralogy Staff Conference
Monday—4:15 p.m.—2d—Surgical-Medical Conference
Tuesday—12:30 p.m.—Weekly—Orthopedic Stoff Conference (1st Tuesday Statistical)
Tuesdoy—4:30 p.m.—Weekly—Surgicol Staff Conference (4th Tuesdoy Stotisticol)
Tuesdoy—4:30 p.m.—1st—Tumor Conference with Tumor Boord
Tuesday—4:15 p.m.—Last—Ophtholmology Stoff Conference
Tuesdoy—4:45 p.m.—Last—Otorhinolaryngology Staff Conference
Tuesday—3:30 p.m.—4th—Anesthesiology Staff Conference (every other month beginning in January)
Thursday—8:00 o.m.—2d & 4th—Psychiatric Stoff Conference
Thursday—12:30 p.m.—1st—Pediotric Stoff
Friday—8:00 o.m.—Weekly—Medical Staff Conference
Friday—12:30 p.m.—Last—Quarterly Generol Stoff Meeting
Friday—12:30 p.m.—3d—Dental Staff
Saturday—7:30 o.m.—Weekly—Surgicol Grond Rounds
Saturdoy—7:30 a.m.—Last Integrated surgical statisticol—in rotation with Queen's, St. Froncis, ond Kuokini

### St. Francis

Manday—4:00 p.m.—Weekly—Surgical Lectures
Manday—12:30 p.m.—4th—Combined CPC (with Queen's ond Kuakini Hospitals)
Tuesday—1:00 p.m.—1st, 2d, 3d—Medical Conference
Tuesdoy—1:00 p.m.—4th—Medical Mortality Conference
Thursday—3:00 p.m.—Weekly—Surgicol Anotomy Conference
Thursday—7:30 p.m.—4th—Med. Jaurnal Club
Friday—7:15 a.m.—1st & 3d—Surgical Conference
Friday—7:15 o.m.—2d—Tumor Conference
Fridoy—7:15 o.m.—4th or 5th—Surgical Statistical Conference
Fridoy—12:30 p.m.—1st, 2d, 3d—Ob-Gyn Meeting
Friday—12:30 p.m.—4th—Ob-Gyn Statisticol Meeting
Friday—8:30-10:00 a.m.—Ob-Gyn Meeting when Visiting Profassor scheduled
Friday—3:00 p.m.—1st & 3d—X-ray Conference

## SPECIALTY SOCIETIES

### Am. Col. Chest Physicians, Hawaii Chapter

Regent—Dr. F. L. Giles Governar—Dr. M. I. Brodsky
Meets as announced

### Am. Col. Physicians, Hawaii Chapter

Dr. Morton E. Berk
Meets as announced

### Am. Col. Surgeons, Hawaii Chapter

Meets as announced
Pres.—Dr. K. S. Tom Sec.-Treas.—Dr. Corl Mason

### Hawaii Academy of General Practice

Meets as annaunced
Pres.—Dr. Robert Chung Sec.-Treos.—Dr. Lawrence Wong

### Hawaii Dermatological Society

Meets 2d Wednesdoy af each month, 8:30 a.m. ot Tripler
Pres.—Dr. Edward Emuro Sec.-Treos.—Dr. Daniel Palmer

### Hawaii Eye, Ear, Nose, and Throat Society

Meets 3d Thursday of each manth at 6:30 p.m.
Pres.—Dr. Wallace Kawaaka Sec.-Treas.—Dr. Vernon Jim

### Hawaii Society of Anesthesiologists

Meets as announced
Pres.—Dr. Luke Tajimo Sec.-Treas.—Dr. John Roberts

### Hawaii Society of Internal Medicine

Meets as announced
Pres.—Dr. Fronk Bruce Sec.-Treos.—Dr. Raymond deHoy

### Hawaii Society of Pathologists

Meets as announced
Pres.—Dr. Paul Tamura Sec.-Treas.—Dr. Frank Fukunogo

### Hawaii Thoracic Society

Meets as annaunced
Pres.—Dr. Frank Miller Sec.-Treas.—Dr. William Myer

### Hawaii Urological Society

Meets os onnaunced
Pres.—Dr. R. K. Maakini Sec.-Treas.—Dr. Lee Simmons

### Hawaii Surgical Society

Meets Bi-monthly, 2d Tuesday
Pres.—Dr. Keith Kuhlman Sec.-Treos.—Dr. Roy Iritani

### Honolulu General Surgical Society

Meets as announced
Pres.—Dr. James Cherry Sec.-Treas.—Dr. Rene Joyeuse

### Honolulu Obstetrical & Gynecological Society

Meets 3d Monday of each month, at 7:30 p.m.
Pres.—Dr. Robert G. Hunter Sec.-Treas.—Dr. Samuel Buist

### Honolulu Pediatric Society

Meets 3d Thursday of each month
Pres.—Dr. R. Y. Hagino Sec.-Treas.—Dr. Betty Soo

### Psychiatric Society of Hawaii

Meets as announced
Pres.—Dr. Walter Char Sec.-Treas.—Dr. Mourice Howell

### Radiological Society of Hawaii

Meets 3d Manday of each manth
Pres.—Dr. Gearge Henry Sec.-Treos.—Dr. Donald Ikeda

### Western Orthopedic Assn., Hawaii Chapter

Meets 3d Wednesday of each month at 7:30 p.m.
Pres.—Dr. William Gulledge Sec.-Treas.—Dr. Ivor Lorsen

## MEETINGS

### HMA 111th Annual Meeting—Honolulu

May 17-21

*For Additional Copies Call Either Summers Prescription Shop, #1—576-378, #2—941-9021*

FREE DELIVERY
CHARGE PRIVILEGES

*Our Pills and Potions Are the Best of the Best*
*Our Prescription Service Has Stood the Time Test*

SUMMERS PRESCRIPTION SHOPS

349 YOUNG BLDG.
576-378

416 ALA MOANA BLDG.
941-9021




# Phenaphen® with Codeine

the only leading compound analgesic that calms instead of caffeinates

*Each capsule contains:*

Phenobarbital (¼ gr.) ..... 16.2 mg.
*(Warning: may be habit forming)*
Aspirin (2½ gr.) .....162.0 mg.
Phenacetin (3 gr.) .....194.0 mg.
Hyoscyamine sulfate .....0.031 mg.
Codeine phosphate.....¼ gr. (No. 2), ½ gr. (No. 3), 1 gr. (No. 4)
*(Warning: may be habit forming)*

*Contraindications:* Hypersensitivity to any ingredient.

*Precautions:* As with all phenacetin-containing products, avoid excessive or prolonged use.

*Side Effects:* Side effects are uncommon—nausea, constipation, and drowsiness have been reported.

A-H-ROBINS

A. H. ROBINS CO., INC., Richmond, Va. 23220

and the HMSA were in communication with one another. Action on the Cancer Society's offer to provide speakers or films on colon and rectal cancer was deferred until next year. It was voted to approve Dr. Luke's Cardiac Resuscitation Program with Dr. Miyashiro as director. In response to the HMA's VD Committee request, all physicians were urged to report all cases of VD as they occur. Discussion on cytology screening and available Health Department funds was tabled. It was voted to request additional information from HMA on liability insurance.

There was 100 per cent attendance at the November 1 meeting when the Cytology Program was discussed. Dr. Emrick advised that after communicating with the Cancer Society and the HMA Cancer Committee it was concluded that the Department of Health should at this time discontinue its part in the cancer cytology programs. After a question relative to the cytology technician for the program, Dr. Emrick advised that a curtailed program would continue. It will be extended should money be made available in the future. It was voted that the cost of the dinner meeting when Dr. Hudson was present be paid from the Society treasury. It was voted to request the visual aid material available on Title XIX from the HMA for showing at the hospitals. It was also voted to advise the HMA that a conflict of date and time made it impossible to extend an invitation and accept the offer of a speaker from the Medicine and Religion Committee.

Dr. Wallis distributed copies of the proposed Declaration of Agreement for Participating Physicians which HMSA had drawn up and presented to the HMA. He stated that in his opinion the Negotiating Committee was in effect stalling and not making a concerted effort to meet with representatives of the HMSA to discuss the issues involved. It was voted to write the President of the HMA and inquire as to the status of the negotiations. Action was deferred on an inquiry from Dr. Koch relative to establishing a practice on Kauai. It was voted to discontinue discussion on the concept of practice of the medical director of Samuel Mahelona Hospital. A report was given by Dr. Kim on the operation of Mahelona Hospital. He advised that he is governed by legislative statutes. With reference to the report that this hospital was contemplating entering into the area of extended care, he advised that the idea was considered but since the Wilcox Hospital was entering into this field, no such program for Mahelona will be entered unless so ordered by the Legislature. The recent report of the HFPC was discussed. A discussion relative to the Society's forming a committee which would make recommendations to the Legislature was deferred. The Nominating Committee's report was submitted and amended. The meeting adjourned after it was voted to obtain clarification about accepting for membership physicians who hold temporary and limited licenses.

Eight members were present at the December 6 meeting where Dr. Duke Cho Choy was the guest speaker. Dr. Choy discussed the role of the practicing physician in the field of medicine and religion and advised that films and literature were available if the Society were interested. He advised that if the members were interested in establishing such a program on Kauai, they should arrange for a meeting with the ministers and the Society members. Speakers from the HMA's Medicine and Religion Committee would be available if the Society felt they could be of assistance.

Approval of the minutes of the previous meeting was tabled until the January meeting. It was voted to invite the HMA President and President-elect to the January 3 meeting. After the reading of a letter from the HMA regarding the acceptance of members with temporary and limited licenses, the application of Dr. Johnston was referred back to the Board of Censors. Dr. Wallis reported

*continued page 257*

OXYGEN AIR-CONDITIONED

*24-HOUR SERVICE*

Physician's



**510-477**

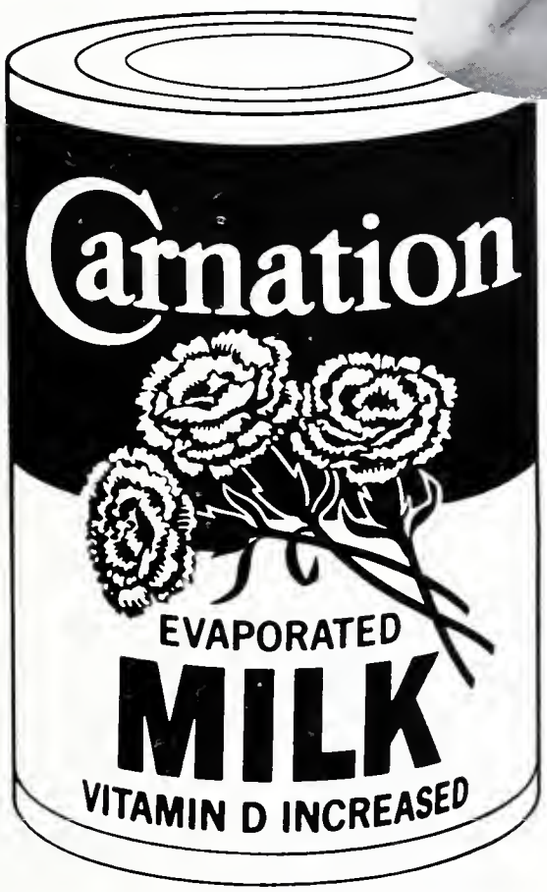
**AMBULANCE SERVICE, INC.**

***Hawaii's Finest***

# Carnation

EVAPORATED MILK

## HAWAII'S HEALTHY BABY MILK...




*"from Contented Cows"*



***1st CHOICE FOR INFANT FEEDING...***
***No. 1 in the Islands for generations,***
***...available everywhere in Hawaii***

1966
Carnation Healthy Baby Contest
$1,000 1st prize winner,
Peter David Keaomalamalama Yoshimi Malo
of Honolulu, Hawaii

# arrest diarrhea




**LOMOTIL**® tablets liquid

Each tablet and each 5 cc. of liquid contains:
diphenoxylate hydrochloride . . . . . 2.5 mg.
(Warning: May be habit forming)
atropine sulfate . . . . . 0.025 mg.

## in gastroenteritis, acute infections

**Effectiveness**— Physiologic evidence indicates that Lomotil acts directly on the smooth muscle of the bowel to lower motility and control diarrhea. This action is unsurpassed in promptness and efficiency.

**Convenience**— Lomotil is available as small, easily carried, virtually tasteless tablets and as a pleasant, fruit-flavored liquid.

**Versatility**— The therapeutic efficiency, safety and convenience of Lomotil may be used to advantage alone or adjunctively in diarrhea associated with:

- **Functional hypermotility**
- **Irritable bowel**
- **Acute infections**
- **Gastroenteritis and colitis**
- **Malabsorption syndrome**
- **Regional enteritis**
- **Ileostomy**
- **Ulcerative colitis**
- **Food poisoning**
- **Drug therapy**

*For correct therapeutic effect*
*Rx correct therapeutic dosage*

*Dosage:* The recommended initial daily dosages, given in divided doses until diarrhea is controlled, are:

**Children: Total Daily Dosage**

3-6 mo. . . ½ tsp.* t.i.d. (3 mg.)
6-12 mo. . ½ tsp.* q.i.d. (4 mg.)
1-2 yr. . . . ½ tsp. 5 times daily (5 mg.)
2-5 yr. . . . 1 tsp. t.i.d. (6 mg.)
5-8 yr. . . . 1 tsp. q.i.d. (8 mg.)
8-12 yr. . . 1 tsp. 5 times daily (10 mg.)
**Adults:** . . 2 tsp. 5 times daily (20 mg.) (or 2 tablets q.i.d.)

*Based on 4 cc. per teaspoonful.

Maintenance dosage may be as low as one-fourth the initial daily dosage.

*Precautions:* Lomotil, brand of diphenoxylate hydrochloride with atropine sulfate, is a Federally exempt narcotic preparation of very low addictive potential. Lomotil should be kept out of reach of children since accidental overdosage may cause severe respiratory depression. Recommended dosages should not be exceeded. Lomotil should be used with caution in patients with impaired liver function and in patients taking addicting drugs or barbiturates. The subtherapeutic amount of atropine is added to discourage deliberate overdosage.

*Side Effects:* Side effects are relatively uncommon but among those reported are gastrointestinal irritation, sedation, dizziness, cutaneous manifestations, restlessness, insomnia, numbness of extremities, headache, blurring of vision, swelling of the gums, euphoria, depression and general malaise.

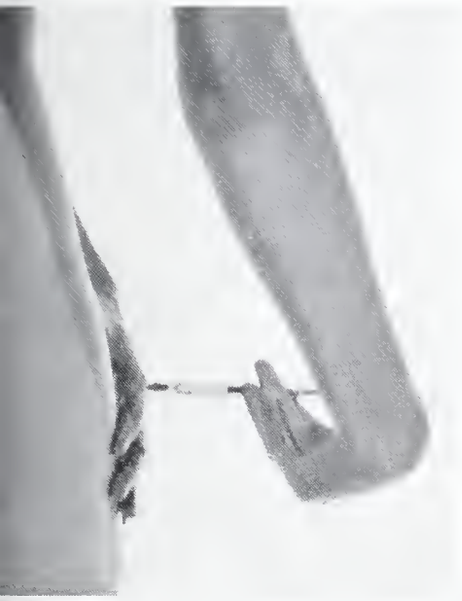
SEARLE *Research in the Service of Medicine*

# New
# low-cost tetracycline/antifungal therapy

## for broad-spectrum activity
## plus specific antifungal prophylaxis
## at significant patient savings

## Whenever tetracycline is indicated in these candidates for Candida:

iabetic patients



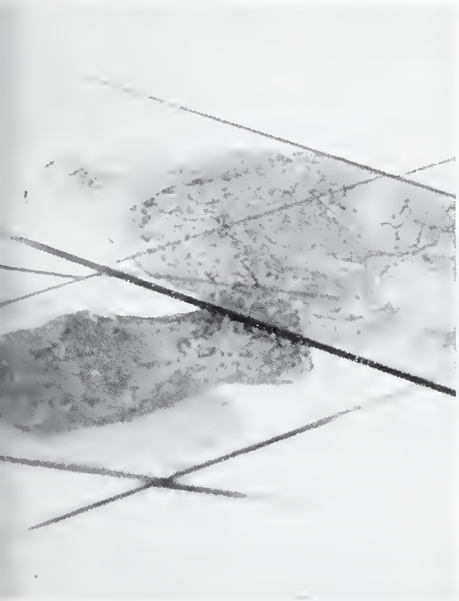
2. nonpregnant women with a history of recent or recurrent monilial vaginitis



3. elderly or debilitated patients



atients with a past history of moniliasis



5. patients on long-term tetracycline or corticosteroid therapy



*BRISTOL THERAPEUTIC SUMMARY:* For complete information consult Official Package Circular. *Indications:* Infections of respiratory, gastrointestinal and genitourinary tracts and skin and soft tissues due to tetracycline-sensitive organisms, in patients with increased susceptibility to monilial infections. *Contraindications:* The drug is contraindicated in patients hypersensitive to its components. *Warnings:* Photodynamic reactions have been produced by tetracyclines. Natural and artificial sunlight should be avoided during therapy. Stop treatment if skin discomfort occurs. With renal impairment, systemic accumulation and hepatotoxicity may occur. In this situation, lower doses should be used. Tooth staining and enamel hypoplasia may be induced during tooth development (last trimester of pregnancy, neonatal period and childhood). *Precautions:* Bacterial superinfection may occur. Infants may develop increased intracranial pressure with bulging fontanels. In gonorrheal therapy, serologic tests for syphilis should be conducted initially and monthly for 3 months. *Adverse Reactions:* Glossitis, stomatitis, nausea, diarrhea, flatulence, proctitis, vaginitis, dermatitis, and allergic reactions may occur. *Usual Adult Dosage:* 1 capsule *q.i.d.* Continue therapy for 10 days in beta-hemolytic streptococcal infections. Administer one hour before or 2 hours after meals. *Supply:* Capsules, bottles of 16. Each capsule contains tetracycline phosphate complex equivalent to 250 mg. tetracycline HCl activity and 250,000 units of nystatin.

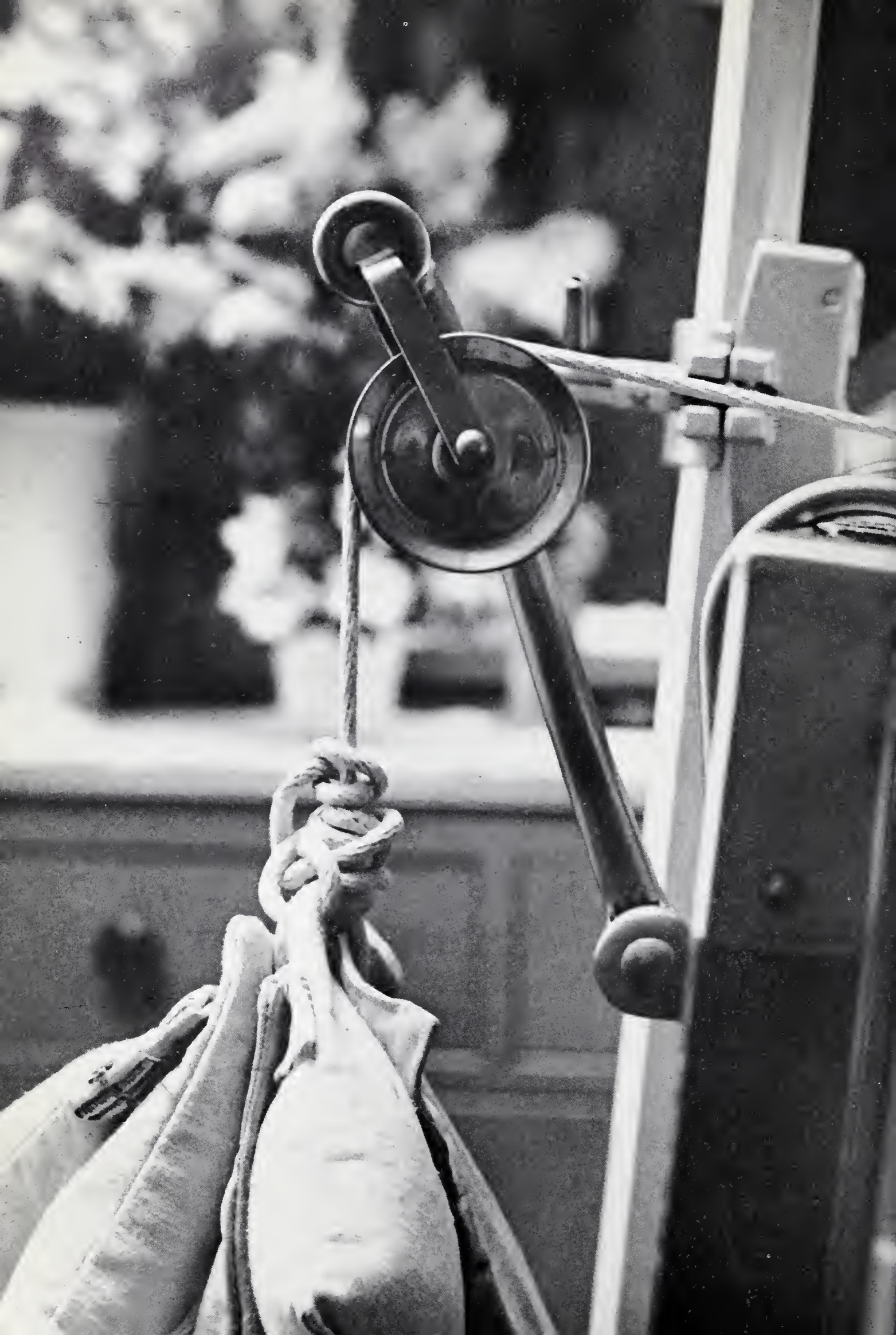
BRISTOL

BRISTOL LABORATORIES
Division of Bristol-Myers Company
Syracuse, New York

# Tetrex-F®

ach capsule contains tetracycline phosphate complex equivalent to tetracycline hydrochloride 250 mg. and nystatin 250,000 units.

## Tetrex-F is priced lower than most tetracycline-antifungal products.





TABLETS

# Equagesic®

## (meprobamate and ethoheptazine citrate with aspirin) Wyeth®

**Precautions:** Keep out of reach of children. Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use of meprobamate may result in dependence or habituation in susceptible persons—as ex-addicts, alcoholics, severe psychoneurotics. Withdraw gradually after prolonged high dosage to avoid possibly severe withdrawal reactions including epileptiform seizures. Warn patients of possible reduced alcohol tolerance. If drowsiness, ataxia or visual disturbances occur, reduce dose. If symptoms persist, caution patients against operating machinery or driving. Give cautiously to patients with suicidal tendencies. Treat attempted suicide with immediate gastric lavage and appropriate supportive therapy

**Side Effects:** Ethoheptazine and aspirin may occasionally cause nausea, vomiting, epigastric distress, and rarely dizziness and CNS depression. Overdosage may result in salicylate intoxication. Meprobamate rarely causes allergic or idiosyncratic reactions. These reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Mild reactions are characterized by urticarial or erythematous maculopapular rash. Acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever have been reported. Meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioedema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. A few cases of leukopenia, usually transient, have been reported following prolonged dosage. Rarely, cases of aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia have been reported; almost always, in the presence of known toxic agents.

**Contraindications:** History of sensitivity or severe intolerance to aspirin or meprobamate.

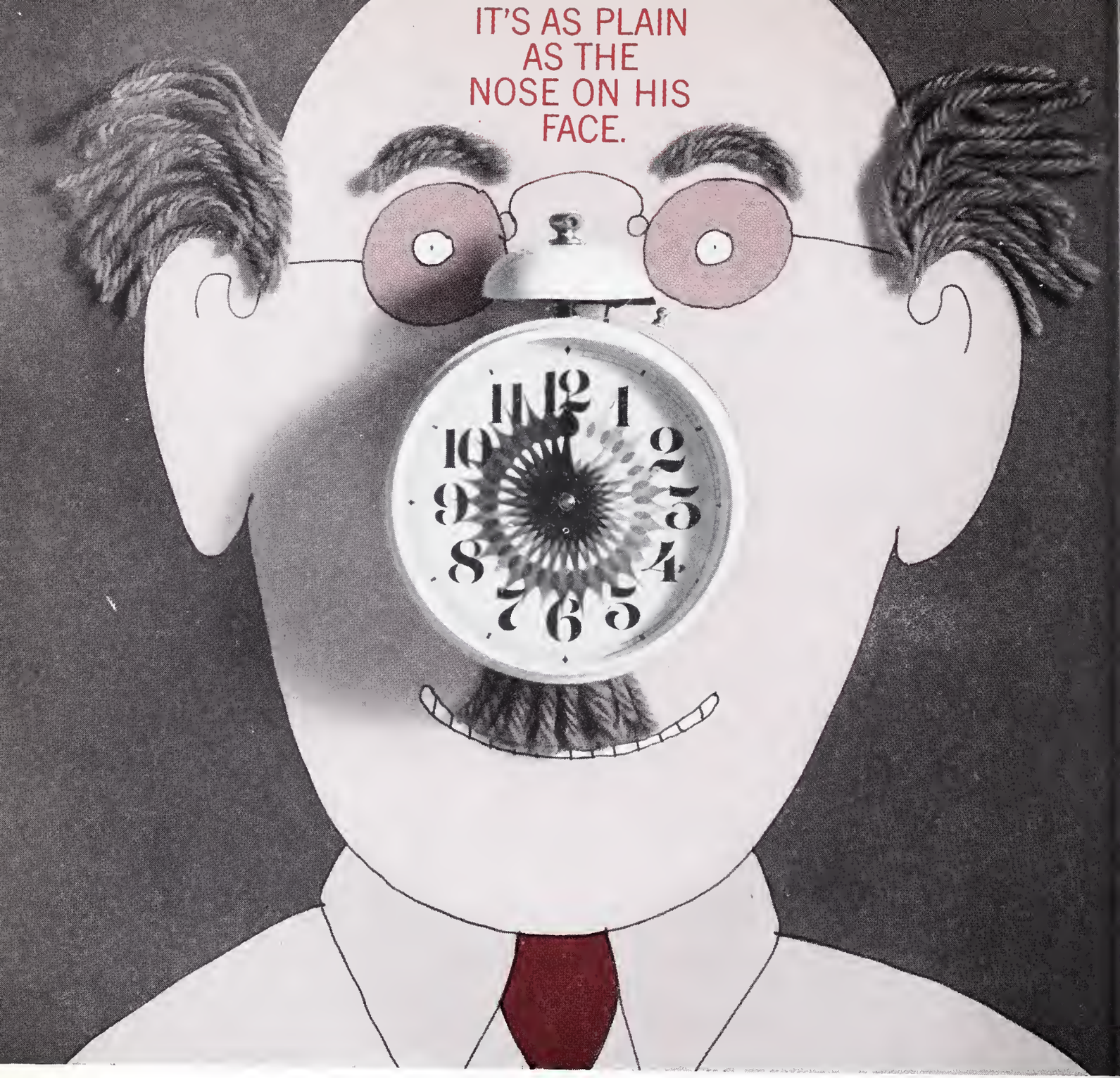
**Composition:** 150 mg. meprobamate, 75 mg. ethoheptazine citrate and 250 mg. aspirin per tablet.

Wyeth Laboratories Philadelphia, Pa.

# Weighing on his mind, too

When pain evokes anxiety and tension, thereby heightening patient discomfort, a simple analgesic may only touch on part of the problem.

This single-prescription, nonnarcotic product, however, usually provides effective analgesia *and* helps put the patient's mind at ease.




UP TO 10-12 HOURS' CLEAR BREATHING ON ONE TABLET

# Dimetapp® Extentabs®

(Dimetane® [brompheniramine maleate], 12 mg.; phenylephrine HCl, 15 mg.; phenylpropanolamine HCl, 15 mg.)

In sinusitis, colds, or U.R.I., Dimetapp lets congested patients breathe easy again. Each Extentab brings welcome relief all day or all night, usually without drowsiness or overstimulation. Its key to success? The Dimetapp formula—Dimetane (brompheniramine maleate), a potent antihistamine reported in one study to have elicited side effects as few as the placebo,* teamed with decongestants phenylephrine and phenylpropanolamine—in a dependable 10- to 12-hour form.

*Schiller, I. W., and Lowell, F. C.: New England J. Med. 261:478, 1959.

*Contraindications:* Patients hypersensitive to antihistamines. Not recommended for use during pregnancy.

*Precautions:* Until the patient's response has been determined, he should be cautioned against engaging in operations requiring alertness. Administer with care to patients with cardiac or peripheral vascular diseases or hypertension.

*Side Effects:* Hypersensitivity reactions including skin rashes, urticaria, hypotension and thrombocytopenia have been reported on rare occasions. Drowsiness, lassitude, nausea, giddiness, dryness of the mouth, mydriasis, increased irritability or excitement may be encountered.

*Dosage:* 1 Extentab morning and evening, or as needed.

*Supplied:* Bottles of 100 and 500.

*Also available:* Dimetapp® Elixir for conventional *t.i.d.* or *q.i.d.* dosage. See package insert for further details.

A. H. ROBINS CO., INC.
RICHMOND, VIRGINIA 23220

A·H·ROBINS

## *County Society Reports* *continued from 250*

on the proposals that the HMSA plans to present to the HMA. The following were elected for the year 1966: Burt O. Wade, President; S. R. Wallis, Vice President; James R. Warner, Secretary-Treasurer; Yonemichi Miyashiro, Chairman of the Board of Censors; William Goodhue, Delegate to HMA; and Robert Emrick, Alternate Delegate to the HMA.

The meeting concluded with a talk by Dr. Choy on "Medicine and Hypnosis."

## Maui

Dr. Charles Hudson, President of the AMA, was honored at a dinner meeting held at the Wailuku Hotel September 16. Dr. Hudson's talk on the impact of Medicare was followed by a question-and-answer period.

* * *

The October 21 dinner meeting was held at the Maui Lu. Dr. and Mrs. Theodore Tomita were special guests. Dr. Tomita discussed some of the areas in which HMA is presently involved. Dr. Uehara reported on the HMA's exploration of including the county societies in its insurance program. It was voted that physicians refuse to answer the Department of Health questionnaires sent out after the Diabetes Survey. Dr. Sowers was authorized to look into the feasibility of holding a joint meeting of physicians and religious leaders. It was decided that the proposal of raising funds for transportation of a psychiatric resident was not proper Society matter for consideration. A total of $100 was reported available for the purchase of books.

The December 18 meeting was held at Kula Lodge. The 1967 dues structure was announced. By unanimous acclamation, warmest Aloha was extended to Dr. Edmund Tompkins on his retirement from active practice. He was automatically placed on the honorary membership roll. Additional activities were suggested for 1967. The outgoing president, Dr. Haling, urged more concerted political action. It was voted to submit the Maui Memorial Hospital on-call list to Hale Makua to provide similar service in the rare event that a patient's private physician is not available. It was unanimously voted that members use the RVS for all groups of patients. The following were elected to office: Billie F. Strother, President; Sakae Uehara, Vice President; John F. Morris, Secretary-Treasurer; Clifford F. Moran and Marion L. Hanlon, HMA delegates; Edward B. Underwood and Milton M. Howell, HMA alternate delegates; and William E. Iaconetti, Councilor. ■

## *Notes and News* *continued from 225*

*Swabbies:* **Ells Harris** is the new Commodore at Waikiki Yacht Club. He and **Fred Shepard** qualified in Cal 20 sloops for the 2d Annual State Sailing Championship Regatta. **Jack Watson** was Class A winner in a Cal 20 as the La Mariana Sailing Club raced at Keehi Lagoon while **"Yosh" Ushiyama** placed 2d in Class B.

*Fishermen:* **Burt Wade** fishing from his *Mari LB* in the Fall Halawai Big Game Fishing Contest caught six ahi, four ono, kawakawa, and many smaller fish.

## Visiting Physicians

Through the courtesy of Merck Sharp & Dohme, we were privileged to hear **Richard Lillehei,** Professor of Surgery at the University of Minnesota Medical School, speak on newer concepts of shock, especially gram-negative septic shock. Aside from the technical jargon, we had a lesson in classical literature, for he drew from world philosophers, Alice in Wonderland, and Shakespearean sonnets. We recognized "Consumed by that which it was nourished by . . ." but failed to grasp what was consumed or what was nourished [the patient?].

Methodical lecturer **David Karnofsky,** Professor of Medicine at Sloan Kettering Institute and Memorial Hospital, was Visiting Professor at The Queen's Hospital in October. We dutifully attended the lectures, hoping for news of some breakthrough in cancer therapy, which did not come.

## Conference Humor

**Richard Lillehei,** discussing shock, made the following observation: "Shock is like pregnancy. It's lots easier to prevent than to treat."

A 61-year-old female with asymptomatic jaundice was found to have a pancreatic head mass at surgery. Multiple biopsies taken were negative. The surgeons debated heatedly whether or not to proceed with a Whipple. Pathologist **Grant Stemmerman** at his rhetorical best related the following: "An aspiring young actress pleaded to the producer, 'I will do anything to get the part.' The producer replied, 'It's not that simple!' "

An esophageal bleeder continued to bleed inspite of a Blakemore Sengstaken tube. **Bob Oishi** maliciously hinted that a true esophageal bleeder should have stopped and that the bleeding could be from another source, whereupon **Walter Chang** rose to the occasion with, "Well, it *looks* like a bear, *smells* like a bear, *growls* like a bear, so I believe it *is* a bear."

## Altarations

Our once happy colony of bachelor physicians has been beating a hasty retreat since confirmed bachelors **Charley Ching** and **Arthur Wong** deserted earlier in the year. In August, **Bob Hunter** married Pat Millard, *Advertiser* homemaking editor and talented medical reporter, in a quiet ceremony at St. Andrew's Cathedral. In September, **Bob Rose** married Abigail Lewis Melim in another quiet wedding at Kawaiahao Chapel. In October, **Ed Jim** somehow made it to New York after a rambunctious stag party at a Nuuanu tea house sponsored by his "friends." He married a Mardie Sughrue, OR headnurse at Columbia Presbyterian Medical Center.

Also in October, shy confirmed bachelor **Mits Tottori** was happily coerced into matrimony by charming Punahou school teacher Jane Hirata. Mits had enough moral support, with brother Hiro acting as best man and his dad Bishop Mitsumyo Tottori officiating at the wedding. **Noboru Ogami** ushered and **Dick Ando** acted as master of ceremonies at the Ilikai reception.

## Members Speak Up

*Fluoridation:* The Battle for Fluoridation resembled the War of 1861; cousin is pitted against cousin, brother against brother, father against son, and doctor against doctor. One of the earlier guns was sounded by **Fred Reppun** in his "Fluoridation is dead. Long live fluoridation!" article in the May-June issue of this JOURNAL. **Harry Arnold, Jr.,** got his dander up and wrote his much quoted editorial, "Reppunzel, Reppunzel, Put Up Your Hair!" in which he described Fred's statement as a "fairy tale, told with hair let down as far as that of the legendary Rapunzel, who also lived in a (nonivory) tower."

During November and December, the trio of **William Moore, Harry Arnold,** and State Dental Chief Manuel Kau debated fluoridation on every available medium—TV, radio, press, and lecture platforms. Editor George Chaplin and reporters Gene Hunter and Barbara Milz helped immeasurably. The *Press* papers reluctantly followed suit, but the Japanese language papers and radio stations, aware of the violent antifluoridation sentiment of the elderly Japanese, remained loyal to their

*continued page 264*



fluocinolone acetonide — an original steroid from

SYNTEX

LABORATORIES INC., PALO ALTO, CALIF.

# controls infected inflammatory dermatoses that start from scratch



# Neo-Synalar®

(fluocinolone acetonide-neomycin sulfate cream)

# Cream

The "itch-scratch" cycle usually associated with inflammation often results in infected dermatoses because broken skin surfaces are particularly vulnerable to pathogenic bacteria.[1] To treat infected inflammatory dermatoses, Neo-Synalar Cream combines the most active topical corticosteroid with a highly reliable antibiotic generally reserved for topical application.

In Neo-Synalar, fluocinoline acetonide controls the inflammation and provides rapid relief from associated pruritus. At the same time, its antibacterial component—neomycin—combats superficial infection caused by many gram-positive and gram-negative bacilli[2] that often colonize and thrive on abraded skin.[1]

A specially formulated vanishing cream base that is greaseless and odor free makes Neo-Synalar cosmetically appealing, and encourages greater patient cooperation.

**controls the infection**

**stops the scratch**

**Contraindications:** Tuberculous, fungal, and most viral lesions of the skin (including herpes simplex, vaccinia, and varicella). Not for ophthalmic use. Contraindicated in individuals with a history of hypersensitivity to any of its components. **Precautions:** Neomycin rarely produces allergic reactions. Prolonged use of any antibiotic may result in overgrowth of nonsusceptible organisms; if this occurs, appropriate therapy should be instituted. Where severe local infection or systemic infection exists, the use of systemic antibiotics should be considered, based on susceptibility testing. While topical steroids have not been reported to have an adverse effect on pregnancy, the safety of their use on pregnant females has not absolutely been established. Therefore, they should not be used extensively on pregnant patients, in large amounts, or for prolonged periods of time. **Side Effects:** Side effects are not ordinarily encountered with topical corticosteroids. As with all drugs, however, a few patients may react unfavorably to Neo-Synalar under certain conditions. **Availability:** Neo-Synalar Cream (0.025% fluocinolone acetonide, neomycin sulfate, equivalent to 0.35% neomycin base), 5 and 15 Gm. tubes.

**References: 1.** Pillsbury, D. M., Shelley, W. B., and Kligman, A. M.: A manual of cutaneous medicine, Philadelphia, Saunders, 1961, p. 79. **2.** Barber, M., and Garrod, L. P.: Antibiotic and chemotherapy, Baltimore, Williams and Wilkins, 1963, p. 111.

# Against these three major pathogens…



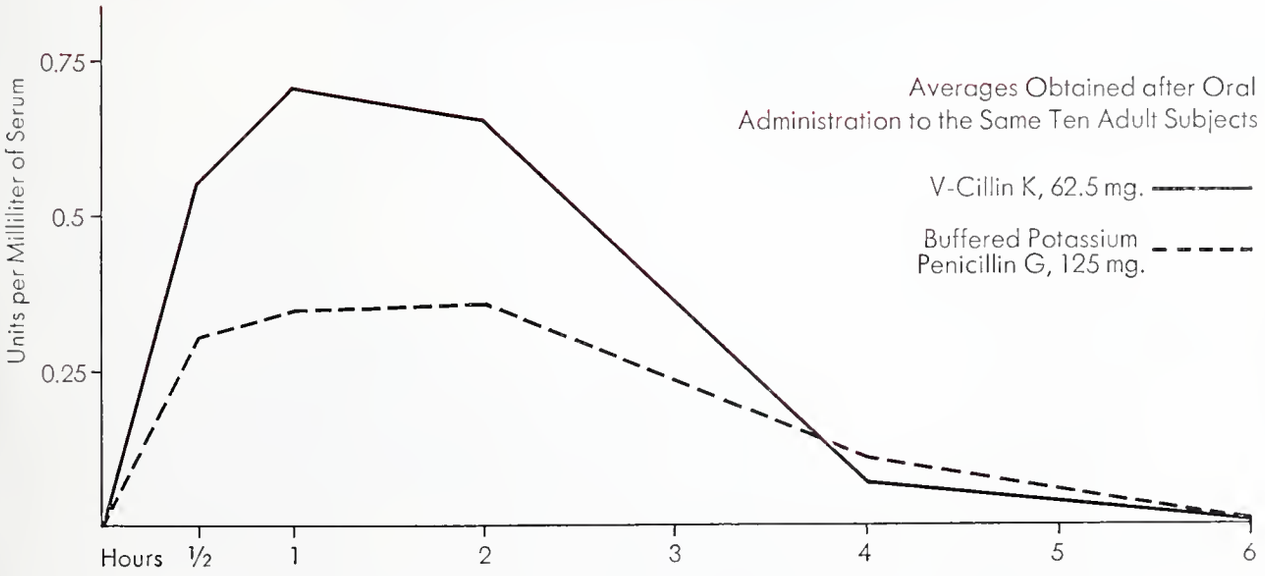
# V-Cillin K® provides unexcelled oral antibacterial activity

## because it combines a high degree of in-vitro activity...

| Antibiotic | Staph. Aureus (Penicillin-Sensitive) MIC (mcg./ml.) Median | Range | Streptococcus, Group A MIC (mcg./ml.) Median | Range | Diplococcus Pneumoniae MIC (mcg./ml.) Median | Range |
|---|---|---|---|---|---|---|
| Penicillin V | 0.02 | 0.02-0.04 | 0.02 | 0.003-0.4 | 0.01 | 0.005-0.2 |
| Penicillin G | 0.02 | 0.005-1.6 | 0.005 | 0.002-0.2 | 0.02 | 0.01-0.1 |
| Methicillin | 1.6 | 0.4-6.3 | 0.2 | 0.1-0.4 | 0.2 | 0.1-1.6 |
| Oxacillin | 0.4 | 0.1-3.1 | 0.04 | 0.02-0.4 | 0.1 | 0.04-0.8 |
| Cloxacillin | 0.2 | 0.2-0.8 | 0.1 | 0.1-0.8 | — | — |
| Nafcillin | 0.4 | 0.2-0.8 | 0.04 | 0.02-0.1 | 0.02 | 0.02-0.2 |
| Ampicillin | 0.2 | 0.1-0.8 | 0.02 | 0.01-0.04 | 0.02 | 0.01-0.04 |

Adapted from Klein, J. O., and Finland, M. New England J. Med ,269 1019, 1963.

## with high blood levels, even in the presence of food




Adapted from Griffith, R. S., and Black, H. R · Current Ther. Res., 6 253, 1964.

**V-Cillin K®** Lilly 700157

**Potassium Phenoxymethyl Penicillin**

*(See next page for prescribing information.)*

# New 500 mg. tablets...a more convenient way to give high doses




**Description:** V-Cillin K is the potassium salt of V-Cillin® (phenoxymethyl penicillin, Lilly). This chemically improved form combines acid stability with immediate solubility and rapid absorption. Higher serum levels are obtained more rapidly with this penicillin than with equal oral doses of penicillin G. The higher serum levels and acid stability of V-Cillin K make it a more dependable penicillin for oral use.

V-Cillin K, Pediatric, is an oral solution of clinically proved V-Cillin K in teaspoon dosage form. When mixed as directed, each 5 cc. (approximately one teaspoonful) will contain 125 mg. (200,000 units) phenoxymethyl penicillin as the potassium salt.

**Indications:** V-Cillin K has been shown to be effective in the treatment of streptococcus, pneumococcus, and gonococcus infections as well as infections caused by sensitive strains of staphylococci. It may be used for the prophylaxis of streptococcus infections in patients with a history of rheumatic fever and for the prevention of bacterial endocarditis after tonsillectomy and tooth extraction in those patients with a history of rheumatic fever or congenital heart disease.

**Contraindication:** V-Cillin K should not be administered to a patient with a history of penicillin hypersensitivity.

**Precautions:** V-Cillin K should be used cautiously, if at all, in a patient with a strongly positive history of allergy. Reactions occur more frequently in individuals with bronchial asthma or other allergies or in those who have previously demonstrated sensitivity to penicillin. If hypersensitivity reactions occur, the drug should be discontinued.

**Adverse Reactions:** Although serious allergic reactions are much less common with administration of oral penicillin than with intramuscular forms, skin rash, symptoms resembling those of serum sickness, or other manifestations of penicillin allergy may occur. When penicillin is administered, measures for treating anaphylaxis should be readily available. Those include epinephrine, oxygen, and pressor drugs for relief of immediate allergic manifestations as well as antihistamines and corticosteroids for delayed effects.

The use of antimicrobial agents may be associated with the overgrowth of antibiotic-resistant organisms; in such a case, antibiotic administration should be stopped and appropriate measures taken.

**Administration and Dosage:** For Tablets V-Cillin K and for V-Cillin K, Pediatric, the usual dosage ranges from 125 mg. (200,000 units) three times a day to 500 mg. (800,000 units) every four hours. For infants, the daily dosage may be 50 mg. per Kg. of body weight divided into three doses.

Beta-hemolytic streptococcus infections without associated bacteremia may be treated with 200,000 to 400,000 units three times a day. Therapy should be continued for a minimum of ten days to prevent development of rheumatic fever and/or other serious complications. Dosage for routine streptococcus prophylaxis in patients with a history of rheumatic fever or congenital heart disease may be 200,000 units once or twice daily. When such patients undergo tonsillectomy, tooth extraction, or other minor surgery, the prophylactic dose should be 500,000 units every six hours given two days prior to surgery and for two days postoperatively. If oral medication is not feasible on the day of surgery, parenteral therapy should be considered. Mild to moderately severe pneumococcus pneumonia has been treated effectively with 250 mg. every six hours.

In staphylococcus infections, 400,000 units or more should be given every six to eight hours in conjunction with indicated surgical procedures.

For gonorrhea in males, 500 mg. (800,000 units) every six hours for three doses may be employed; in females, 500 mg. every four hours for six doses are recommended. Patients with a suspected lesion of syphilis should have a dark-field examination before receiving penicillin and monthly serologic tests for a minimum of three months.

**How Supplied:** Tablets V-Cillin K, U.S.P., 125 mg. (200,000 units), in bottles of 50 and 100; 250 mg. (400,000 units), and 500 mg. (800,000 units) in bottles of 24 and 100.

V-Cillin K, Pediatric, for Oral Solution, 125 mg. (200,000 units) per 5 cc. of solution, in 40, 80, and 150-cc.-size packages.

*Additional information available to physicians upon request. Eli Lilly and Company, Indianapolis, Indiana 46206.*

Lilly

700157

ONLY 20 MINUTES FROM
DOWNTOWN HONOLULU . . .

# KAHANAOLA

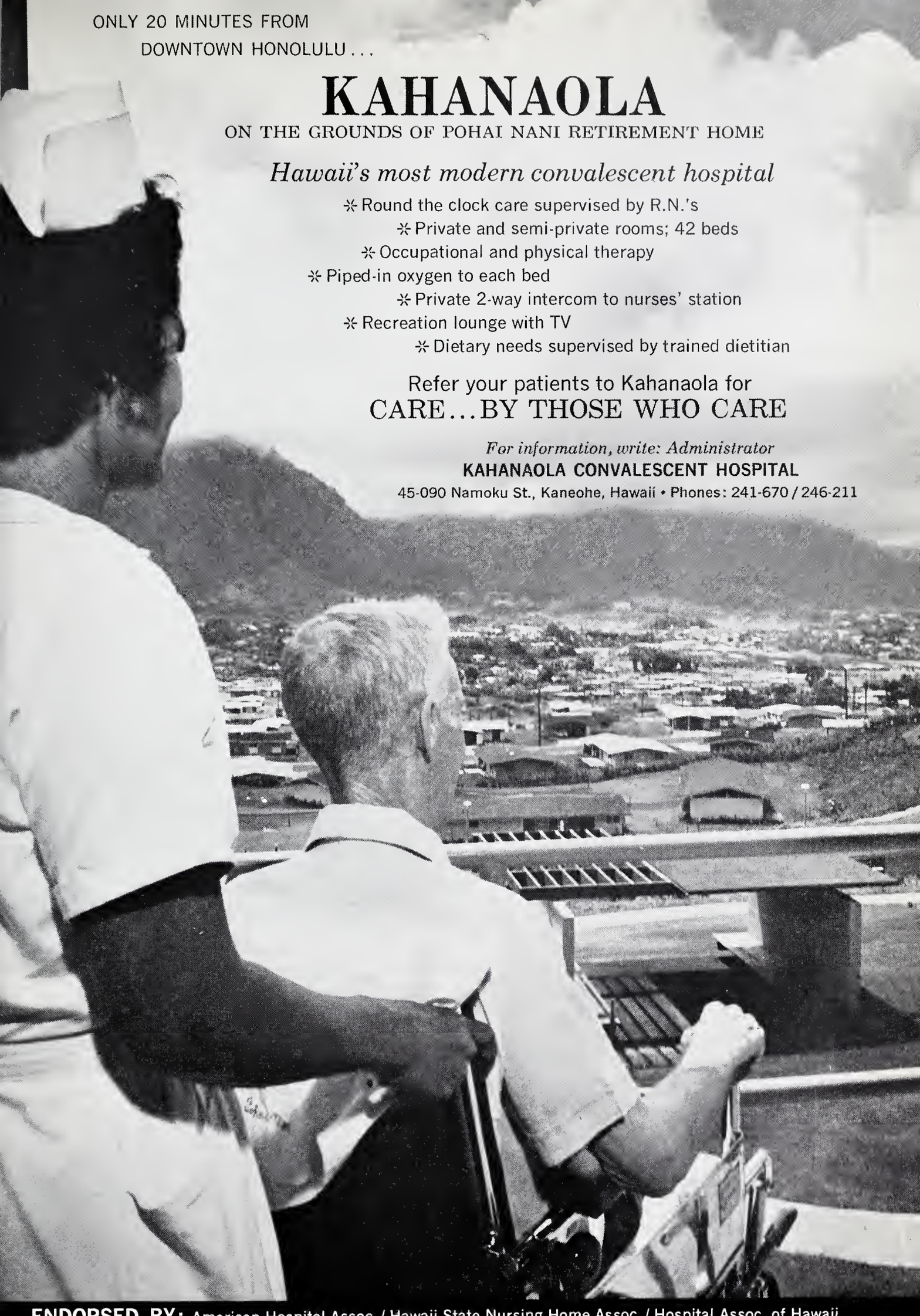
ON THE GROUNDS OF POHAI NANI RETIREMENT HOME

*Hawaii's most modern convalescent hospital*

- Round the clock care supervised by R.N.'s
- Private and semi-private rooms; 42 beds
- Occupational and physical therapy
- Piped-in oxygen to each bed
- Private 2-way intercom to nurses' station
- Recreation lounge with TV
- Dietary needs supervised by trained dietitian

Refer your patients to Kahanaola for
CARE . . . BY THOSE WHO CARE

*For information, write: Administrator*
**KAHANAOLA CONVALESCENT HOSPITAL**
45-090 Namoku St., Kaneohe, Hawaii • Phones: 241-670 / 246-211



**ENDORSED BY:** American Hospital Assoc. / Hawaii State Nursing Home Assoc. / Hospital Assoc. of Hawaii
American Nursing Home Assoc.

**APPROVED FOR PAYMENT BY** HAWAII MEDICAL SERVICE ASSOC.

misinformed readers and listeners. In the face of this emotional situation, **Shigeo Natori** and **Keiichi Goshi** of our Japanese Speakers Bureau braved an openly hostile element to present fluoridation data in the two Japanese dailies and stations KOHO and KZOO. When Shigeo jokingly remarked that those who did not wish to drink fluoridated water could very well dig their own wells, the emotional bigots of the Citizens for Pure Water lambasted him with anonymous calls for days on ends. Through it all, Shigeo remained "head bloodied, but unbowed."

On Maui, **Marion Hanlon** and Howard Miyamoto did their share at PTA meetings. Both age-extremes were pacified. **Gene Ahern** in "Keiki Care" made the point that fluoridation should be started early, the last six months of the infants development and **Harry Arnold** pointed out that fluorides are good even for our older citizens by preventing the loss of calcium from their bones. **Bill Moore** introduced the personal sidelight that his own kids take fluoride-vitamin pills, but fail to take them regularly. Manuel Kau pointed out that topical application and fluoride pills were about 35 per cent effective at best, while fluoridation gave 65 per cent over-all reduction in tooth decay and 95 per cent reduction in front tooth decay. Among the unheralded were **Don Ikeda** who went out in his own neighborhood and collected over 250 signatures and made personal telephone calls to the councilmen. **Mits Tottori** patiently talked fluoridation to all his patients and their parents.

The Anti's marshalled their forces slowly, but effectively. They sprang a surprise with eloquent **Keith Kuhlman** as guest speaker on Joe Rose's "Gripe Box" and **Bob Katsuki** wrote an effective letter which was read at the HIC hearings. Traditional antifluoridationist **Lyle Phillips** was on hand to present the time-honored argument that fluoridation had "not been adequately tested." Most of the arguments were stereotyped and looked pallid in the face of overwhelming profluoridation data, but the more intelligent, like **Fred Reppun,** accepted the scientific facts and were more concerned with the matter of rights. Fred wanted to preserve his rights, "Among these was the right not-to-be-done-good-to," which apparently stemmed from an unhappy childhood experience when his mother forced him to eat his vegetables. We enjoyed his argument that, "If fluoridation ever becomes a mandate of the law, the basic problem: Neglect, Ignorance, Carelessness, will not have been buried by it. The do-gooders, nevertheless, may well carve an epitaph over the empty grave: 'We used a cannon to shoot at a gnat. Maybe the gnat will go away.'" To paraphrase a cigaret ad, "Us do-gooders would rather fight than switch."

*Other topics:* Olympic trainer, originator of the now famous XDR (exercise, diet and rest) system, and prospective politico **Richard W. You** added his suggestion "on how to win with the least expense and loss of men." He wrote President Johnson last January suggesting "that a steel curtain be erected between North and South Viet Nam and the surrounding countries in order to prevent infiltration and supplies from reaching the Viet Cong and troops of North Viet Nam already in South Viet Nam." Now, why couldn't we have thought of something as simple as that?

Pragmatist **Mort Berk,** new Chief of Staff at Queen's and key speaker at the Hawaii Congress of Parents and Teachers, extolled the dangers of smoking and pointed out how PTA members could help in a drive to prevent youngsters from starting to smoke. "If they could get smoking parents to quit, perhaps the kids would be impressed. How can you tell a child he should not smoke if you have a lighted cigaret in your own hand?" Great minds grasp the simple truths.

Newly installed Honolulu County President and nearly successful Lt. Governor candidate **George Mills** encouraged Honolulu County Medical Society members to "take a more positive, bold, and aggressive role, not only in the pure medical environment of Hawaii, but also in the economics, education, and government of this State. If we do not do this, medicine as we know it today will be relegated to a secondary position."

Amiable **L. T. Chun** was a panel speaker on sex education at the Kainalu Elementary School PTA. Hometown-boy-who-made-good-in-the-big-city **Masato Hasegawa** was guest speaker for the Teenage Program of the National Foundation March of Dime's TAP Kickoff in Hilo. He explained the care, prevention, and the most recent discoveries in the Birth Defect Program of the March of Dimes. **Duke Cho Choy** spoke at August Ahrens School's PTA on mental health problems involving parents and children.

Hard-working **Unoji Goto,** Hawaii Heart Association President, spoke at the Windward Unit to familiarize leaders of the "Heart Sunday" fund drive. The $100,000 allotted the Heart Association through the Aloha Fund leaves $135,000 in their annual budget which has to be raised on their own.

**Grant Stemmerman** presented a paper on stomach cancer studies at the Ninth International Cancer Congress in Tokyo recently. He feels that Hawaii's Japanese population could play a pivotal role in the study of stomach, colon, and rectal cancers because one of the causes of the disease in these sites is suspected to be dietary. Since the Japanese-American diet has undergone change, he feels that this makes comparative studies feasible. He hopes to find specific antibodies to fight the reproduction of the stomach cancer cells.

When asked by the *Star-Bulletin* Inquiring Reporter, "When are you at your best?" **David Tien** of Wahiawa replied with Christian sincerity, "I think I'm always at my best. I'm always happy. I'm a faithful Christian, that might have something to do with it." Amen. ■

**MEDICAL PLACEMENT BUREAU**
**and**
**NURSES' REGISTRY**

24 HOUR SERVICE

**LET US SERVE YOU IN YOUR NEED**

Nurses, Staff and Office
Nurses, Private Duty
Nurses, Supervisors
Practical Nurses
Nurses, Aide
Dental Assistants
Physical Therapists
X-Ray Technicians
Laboratory Technicians
Medical Stenographers
Medical Clerks
Receptionists
Male Nurses
Bookkeepers
Home Companions

Frieda M. Beezley, R.N., *Director*
Patsy Harrison, *Secretary*

**1473 South King St.** **991-237**



Photo professionally posed

# Mike expects a penicillin injection. He's about to be pleasantly surprised.

His physician is going to prescribe an oral penicillin —Pen•Vee® K (potassium phenoxymethyl penicillin). It's usually so rapidly and completely absorbed that therapeutic serum levels are produced in 15 to 30 minutes. Higher serum levels generally last longer than with oral penicillin G.

**Indications:** Infections due to pathogens susceptible to oral penicillin G. Prophylaxis of rheumatic fever in patients with previous history of the disease.

**Precautions:** Skin rash, symptoms resembling those of serum sickness, or other manifestations of penicillin-allergy may occur. Measures for treating anaphylaxis should be readily available: epinephrine, oxygen and pressor drugs for relief of immediate allergic reactions; antihistamines and corticosteroids for delayed effects. Penicillin may delay or prevent the appearance of primary syphilitic lesions. Patients with gonorrhea who are suspected of concurrent syphilitic infections should be tested serologically for at least 3 months. Where lesions of primary syphilis are suspected, dark-field examination should precede use of penicillin. As with other antibiotics overgrowth of nonsusceptible organisms may occur; if so, discontinue and take appropriate measures. Treat β-hemolytic streptococcal infections with full therapeutic dosage for at least 10 days to prevent development of rheumatic fever or glomerulonephritis.

**Contraindications:** Infections caused by nonsusceptible organisms; history of penicillin sensitivity.

**Composition:** Tablets—125 mg. (200,000 units) and 250 mg., (400,000 units); Liquid—125 mg. (200,000 units) and 250 mg. (400,000 units) per 5 cc.

Wyeth Laboratories Philadelphia, Pa.

ORAL **Pen•Vee® K**
**(potassium phenoxymethyl penicillin)** Wyeth®

# Our "Angels"


Ames Company, Inc.
*Dextrostix* ..... 177
*Labstix* ..... 237

Amfac, Inc. ..... 187

Ayerst Laboratories
*Auralgan* ..... 179
*Premarin* ..... 268

Bristol Laboratories
*Polycillin Caps* ..... 188, 189
*Tetrex-F* ..... 253

Burroughs Wellcome & Co. (U.S.A.) Inc.
*Neosporin* ..... 239

Carnation Co. ..... 251

Cen-Pac Properties, Inc. ..... 238

Ciba Pharmaceutical Co.
*Doriden* ..... 241

Coca-Cola Bottling Co. of Honolulu ..... 242

Eastman Kodak Co. ..... 196, 197

Financial Management Institute ..... 240

Geigy Pharmaceuticals
*Preludin* ..... 180, 181

General Diagnostics
*Simplastin-A* ..... 235

Hawaii Camera ..... 234

Hawaii Medical Service Association ..... 236

Hawaiian Airlines ..... 242

Hynson, Westcott & Dunning
*Lactinex* ..... 175

Kahanaola ..... 263

Laniolu ..... 244

Lederle Laboratories
*Stresscaps* ..... 190
*Tine Test* ..... 243

Lilly, Eli, & Co.
*Cordran* ..... 200
*Darvon* ..... 173
*Ilosone* ..... 184, 185, 186
*V-Cillin-K* ..... 260, 261, 262

Medical Placement Bureau ..... 264

Merrell, The Wm. S., Co.
*Alertonic* ..... 192, 193

O'Leary, Lydia, of Hawaii
*Covermark* ..... 266

Optical Dispensers ..... 248

Parke, Davis & Co.
*Chloromycetin* ..... 174

Physician's Ambulance Service ..... 250

Pitman-Moore
*Novahistine-LP* ..... 182, 183

Robins, A. H. Co., Inc.
*Dimetapp* ..... 256
*Ambar #2 Extentabs* ..... 191
*Phenaphen* ..... 249

Roche Laboratories
*Librium* ..... 267

Schuman Carriage Co., Ltd.
*Cadillacs* ..... 246

Searle, G. D., & Co.
*Lomotil* ..... 252

Star-Bulletin Printing Co. ..... 248

Summers Prescription Shops ..... Insert

Syntex Laboratories, Inc.
*Neo-Synalar* ..... 258, 259
*Norinyl* ..... 194, 195

Williams Mortuary ..... 240

Wine Advisory Board ..... 247

Winthrop Laboratories
*Phisohex* ..... 245

Wyeth Laboratories
*Equanil* ..... 198, 199
*Pen Vee K* ..... 265
*Serax* ..... 230, 231
*Tubex* ..... Insert (between 186 & 187)
*Equagesic* ..... 254, 255





**BLEMISHES?**

COVERMARK conceals all skin discolorations . . . birthmarks, brown & white patches, broken veins, tattoos, burns, scars, on any part of the body. COVERMARK is also unexcelled as an overall makeup . . . will not rub or flake off. Waterproof and Sunproof.

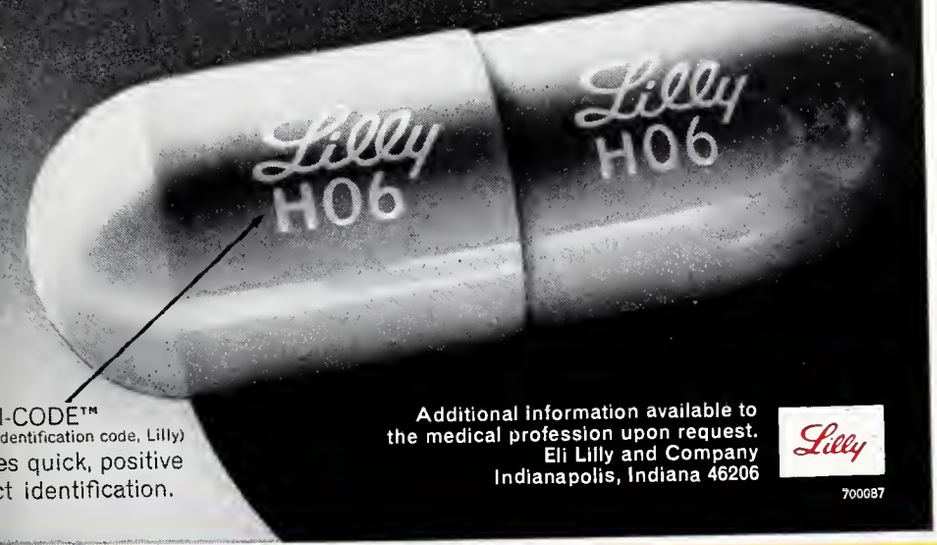
*Lydia O'Leary*
OF HAWAII
ALA MOANA CENTER—STREET LEVEL
PHONE 993-288

March-April, 1967

# HAWAII MEDICAL JOURNAL

U.C. MEDICAL CENTER LIBRARY
APR 25 1967
San Francisco

Something special
Darvon® Compound-65
Each Pulvule® contains 65 mg. propoxyphene hydrochloride, 227 mg. aspirin, 162 mg. phenacetin, and 32.4 mg. caffeine.




-CODE™
dentification code, Lilly)
es quick, positive
ct identification.

Additional information available to the medical profession upon request.
Eli Lilly and Company
Indianapolis, Indiana 46206
Lilly
700087




*In this issue*

**111th Annual Meeting**
**May 17-20**
**Princess Kaiulani Hotel**

## Acute Diarrheas of Childhood

*Table of contents, page 274*

VOLUME 26 • NUMBER 4


when it counts...
Chloromycetin®
(chloramphenicol)
PARKE-DAVIS
PARKE, DAVIS & COMPANY, Detroit, Michigan 48232
Complete information for usage
available to physicians upon request.
01366

# Lutrexin®

## HW&D BRAND OF LUTUTRIN

### 3000 UNIT TABLETS

**IN THE TREATMENT OF FUNCTIONAL DYSMENORRHEA AND SELECTED CASES OF PREMATURE LABOR AND 2ND AND 3RD TRIMESTER THREATENED ABORTION**

In controlling abnormal uterine activity, LUTREXIN, the non-steroid "uterine relaxing factor" has been found to be the drug of choice by many clinicians.

No side effects have been reported, even when massive doses (25 tablets per day) were administered.

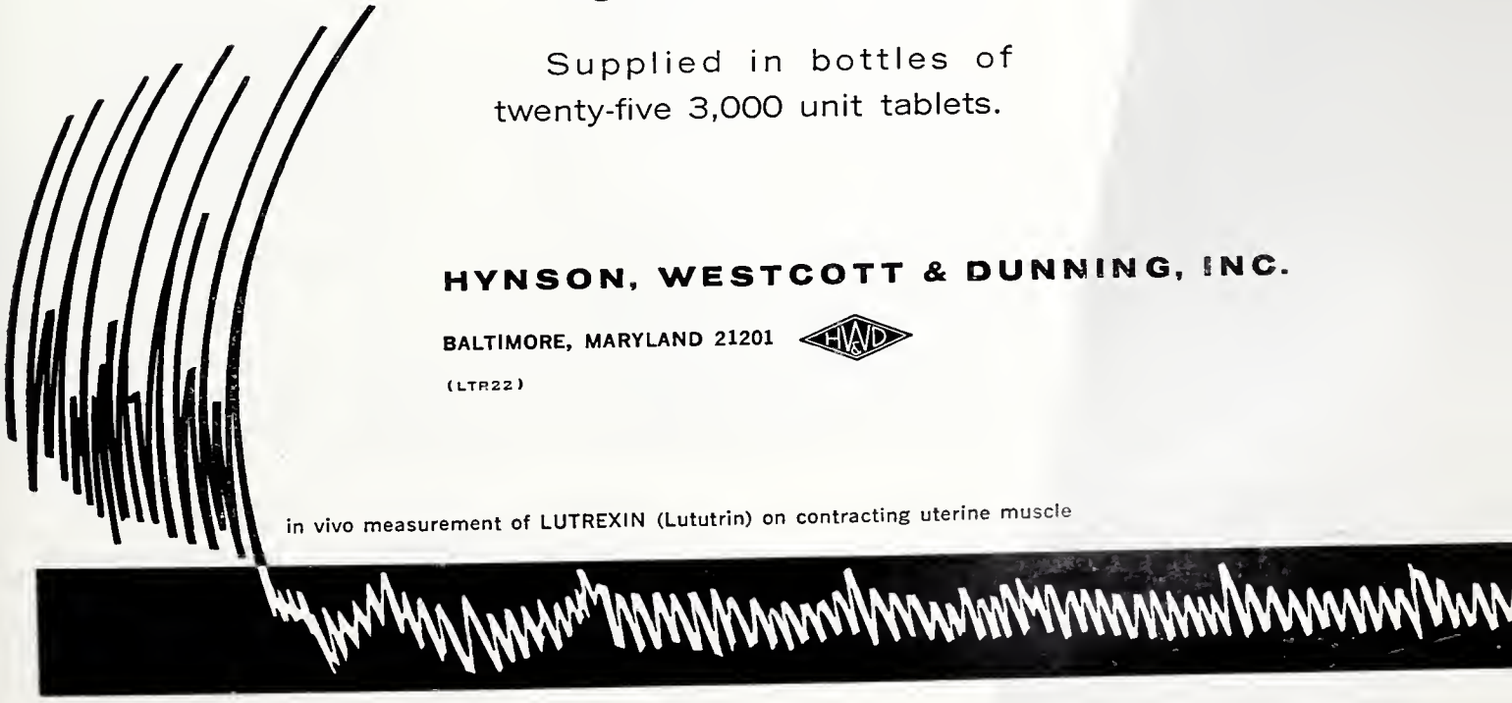
Literature on indications and dosage available on request.

Supplied in bottles of twenty-five 3,000 unit tablets.

**HYNSON, WESTCOTT & DUNNING, INC.**

BALTIMORE, MARYLAND 21201 HW&D

(LTR22)



in vivo measurement of LUTREXIN (Lututrin) on contracting uterine muscle

HAWAII MEDICAL JOURNAL

*Published Bi-Monthly by the* HAWAII MEDICAL ASSOCIATION (Incorporated in 1856 under the Monarchy), 510 S. Beretania St., Honolulu, Hawaii 96813 • *Editor,* HARRY L. ARNOLD, JR., M.D. • *News Editor,* HENRY N. YOKOYAMA, M.D. • *Managing Editor,* LEE MCCASLIN

VOLUME 26, NUMBER 4 • MARCH-APRIL, 1967 • $6.00 A YEAR, $1.00 A COPY

The JOURNAL may not be held responsible for opinions expressed in papers, discussions, communications, or advertisements. The advertising policy of the HAWAII MEDICAL JOURNAL is governed by the rules of the Council on Drugs of the American Medical Association. The right is reserved to reject material submitted for editorial or advertising columns. All material for publication must be in the hands of the editor on or before the 10th day of the month preceding publication date. Reprints of original articles will be supplied at actual cost, provided request is attached to manuscript or made in sufficient time before publication. A reasonable number of cuts and illustrations accompanying an article will be accepted for printing. The right is reserved to ask the author to bear cost of these when it is found necessary to do so.

Copyright, 1967, by the Hawaii Medical Association, Honolulu, Hawaii. Entered as second class matter, October 17, 1941, at the Post Office in Honolulu, Hawaii, under the Act of August 24, 1912. Office of Publication: Mabel L. Smyth Memorial Building, 510 S. Beretania St., Honolulu, Hawaii 96813.

# The Hawaii Medical Association

## Officers 1966-1967

President • THEODORE T. TOMITA, *Honolulu*
President-Elect • B. A. RICHARDSON, *Honolulu*
Past President • O. D. PINKERTON, *Honolulu*
Secretary • R. VARIAN SLOAN, *Honolulu*
Treasurer • HERBERT Y. H. CHINN, *Honolulu*

County Presidents

Hawaii County • ED B. HELMS, *Hilo*
Honolulu County • JOHN J. LOWREY, *Honolulu*
Kauai County • Y. MIYASHIRO, *Waimea*
Maui County • KENNETH HALING, *Kahului*

Delegate to A.M.A. • RICHARD D. MOORE, *Honolulu*
Alt. Delegate to A.M.A. • GEORGE H. MILLS, *Honolulu*

## Councillors 1966-1967

Maui • JOSEPH E. ANDREWS
Honolulu • GROVER H. BATTEN
Honolulu • BERNARD W. D. FONG
Honolulu • ANDREW C. IVY, JR.
Hawaii • ROBERT M. MIYAMOTO
Kauai • SAMUEL R. WALLIS

## Officers — County Societies — 1967

| HAWAII | | HONOLULU |
|---|---|---|
| ETTA WRIGHT BEST • | President | • GEORGE H. MILLS |
| FRANCIS F. C. WONG • | Vice President | • KEITH F. O. KUHLMAN |
| REGINALD S. CARVALHO • | Secretary | • HERBERT Y. H. CHINN |
| JAMES K. MATAYOSHI • | Treasurer | • K. S. TOM |

| KAUAI | | MAUI |
|---|---|---|
| BURT O. WADE • | President | • BILLIE FERN STROTHER |
| SAMUEL WALLIS • | Vice President | • SAKAE UEHARA |
| JAMES P. WARNER • | {Secretary} {Treasurer} | • JOHN F. MORRIS |

# New
# low-cost tetracycline/antifungal therapy

## for broad-spectrum activity
## plus specific antifungal prophylaxis
## at significant patient savings

## Whenever tetracycline is indicated in these candidates for Candida:

iabetic patients



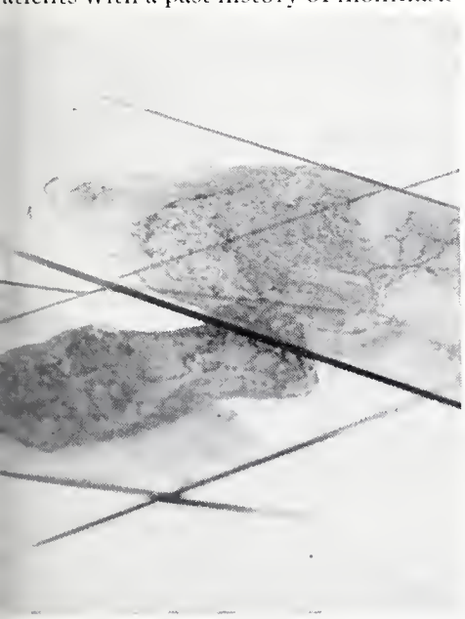
2. nonpregnant women with a history of recent or recurrent monilial vaginitis



3. elderly or debilitated patients



atients with a past history of moniliasis



5. patients on long-term tetracycline or corticosteroid therapy



PRESCRIBING INFORMATION. For complete information consult Official Package Circular. *Indications:* Infections of respiratory, gastrointestinal and genitourinary tracts and skin and soft tissues due to tetracycline-sensitive organisms, in patients with increased susceptibility to monilial infections. *Contraindications:* The drug is contraindicated in patients hypersensitive to its components. *Warnings:* Photodynamic reactions have been produced by tetracyclines. Natural and artificial sunlight should be avoided during therapy. Stop treatment if skin discomfort occurs. With renal impairment, systemic accumulation and hepatotoxicity may occur. In this situation, lower doses should be used. Tooth staining and enamel hypoplasia may be induced during tooth development (last trimester of pregnancy, neonatal period and childhood.) *Precautions:* Bacterial superinfections may occur. Infants may develop increased intracranial pressure with bulging fontanels. In gonorrheal therapy, serologic tests for syphilis should be conducted initially and monthly for 3 months. *Adverse Reactions:* Glossitis, stomatitis, nausea, diarrhea, flatulence, proctitis, vaginitis, dermatitis, and allergic reactions may occur. *Usual Adult Dosage:* 1 capsule q.i.d. Continue for 10 days in Beta-hemolytic streptococcal infections. Administer one hour before or two hours after meals. *Supplied:* Capsules, bottles of 16 and 100. Each capsule contains tetracycline phosphate complex equivalent to 250 mg. tetracycline HCl activity and 250,000 units of nystatin. For Oral Suspension, 125 mg. tetracycline and 125,000 u. nystatin/5 ml., 60 ml. bottles.

BRISTOL

BRISTOL LABORATORIES
Division of Bristol-Myers Company
Syracuse, New York

# Tetrex-F®

Each capsule contains tetracycline phosphate complex equivalent to tetracycline hydrochloride 250 mg. and nystatin 250,000 units.

HAWAII MEDICAL JOURNAL

# Contents

Volume 26, No. 4 • March-April, 1967

**Articles**

*Mycobacterioses: The Case Against Tradition* 301
Drake W. Will, M.D.

*Early Differential Diagnosis and Specific Treatment in the Acute Diarrheas of Infancy and Childhood* 303
F. D. Nance, M.D.

*Deceleration Injury of the Thoracic Aorta* 312
Carl B. Mason, M.D., and G. Campbell Hobson, M.D.

**Editorials**

*Privileges* 318

*. . . a little wine, for thy stomach's sake . . .* 319

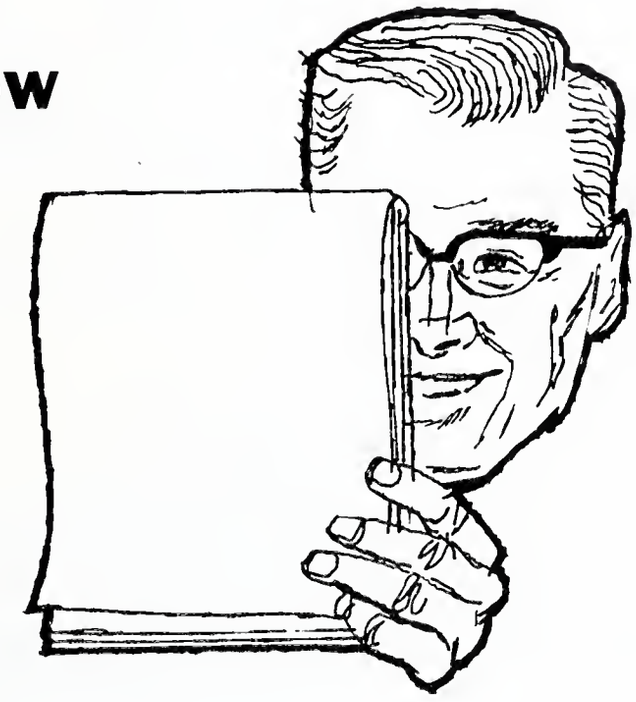
**Features**

*Book Reviews* 322
*County Society Reports* 325
*Hawaii Academy of General Practice* 323
*Hawaii Medical Association* 325
*In Memoriam—Doctors of Hawaii—LXVI* 320
*New Members* 324
*Notes and News* 326
*President's Page* 317
*This is What's New!* 321

**Hawaii Technologists' Bulletin**

*HSMT's Annual Convention—The Eighteenth* 330
*Automation—Continued* 330
*Automation: Various Views from HSMT Members* 331

# Set up a living trust for your family now



# ...and you're the first beneficiary

■ You enjoy the benefits of your investments without the tasks of managing them. You provide for your future years. And you give yourself the assurance you've done the best for your family. The trust can make it possible for them to avoid estate settlement delays, cut settlement costs and decrease estate tax liability.

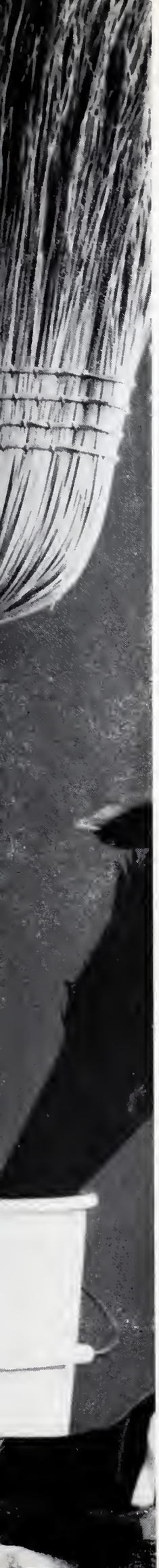
60 1906 1966 ANNIVERSARY **BISHOP TRUST COMPANY**

*Trust Services Exclusively*

Our new booklet, "Financial Security with a Modern Living Trust," shows how you can protect your family and save substantial sums in estate taxes. For a free copy, visit our offices at Bishop & King Sts., write us at P. O. Box 2390, Honolulu 96804, or call 563-771.







Posed by professional model.

# You can't set her free. But you can help her feel less anxious.

You know this woman.

She's anxious, tense, irritable. She's felt this way for months.

Beset by the seemingly insurmountable problems of raising a young family, and confined to the home most of the time, her symptoms reflect a sense of inadequacy and isolation. Your reassurance and guidance may have helped some, but not enough.

SERAX (oxazepam) cannot change her environment, of course. But it can help relieve anxiety, tension, agitation and irritability, thus strengthening her ability to cope with day-to-day problems. Eventually—as she regains confidence and composure—your counsel may be all the support she needs.

Indicated in anxiety, tension, agitation, irritability, and anxiety associated with depression.

May be used in a broad range of patients, generally with considerable dosage flexibility.

**Contraindications:** History of previous hypersensitivity to oxazepam. Oxazepam is not indicated in psychoses.

**Precautions:** Hypotensive reactions are rare, but use with caution where complications could ensue from a fall in blood pressure, especially in the elderly. One patient exhibiting drug dependency by taking a chronic overdose developed upon cessation questionable withdrawal symptoms. Carefully supervise dose and amounts prescribed, especially for patients prone to overdose; excessive prolonged use in susceptible patients (alcoholics, ex-addicts, etc.) may result in dependence or habituation. Reduce dosage gradually after prolonged excessive dosage to avoid possible epileptiform seizures. Caution patients against driving or operating machinery until absence of drowsiness or dizziness is ascertained. Warn patients of possible reduction in alcohol tolerance. Safety for use in pregnancy has not been established.

Not indicated in children under 6 years; absolute dosage for 6 to 12 year-olds not established.

**Side Effects:** Therapy-interrupting side effects are rare. Transient mild drowsiness is common initially; if persistent, reduce dosage. Dizziness, vertigo and headache have also occurred infrequently; syncope, rarely. Mild paradoxical reactions (excitement, stimulation of affect) are reported in psychiatric patients. Minor diffuse rashes (morbilliform, urticarial and maculopapular) are rare. Nausea, lethargy, edema, slurred speech, tremor and altered libido are rare and generally controllable by dosage reduction. Although rare, leukopenia and hepatic dysfunction including jaundice have been reported during therapy. Periodic blood counts and liver function tests are advised. Ataxia, reported rarely, does not appear related to dose or age.

These side reactions, noted with related compounds, are not yet reported: paradoxical excitation with severe rage reactions, hallucinations, menstrual irregularities, change in EEG pattern, blood dyscrasias (including agranulocytosis), blurred vision, diplopia, incontinence, stupor, disorientation, fever, euphoria and dysmetria.

**Availability:** Capsules of 10, 15 and 30 mg. oxazepam.

To help you relieve anxiety and tension

## Serax® (oxazepam)

Wyeth® SERVICE TO MEDICINE

Wyeth Laboratories
Philadelphia, Pa.

# COMMON SENSE
## VS.
# NONSENSE

*"It's unwise to pay too much, but it's worse to pay too little. When you pay too much, you lose a little money — that is all. When you pay too little, you sometimes lose everything, because the thing you bought was incapable of doing the thing it was bought to do. The common law of business balance prohibits paying a little and getting a lot — it can't be done. If you deal with the lowest bidder, it is well to add something for the risk you run, and if you do that you will have enough to pay for something better."*

*— John Ruskin (1819-1900)*

WE AT AMFAC DRUG believe in providing you with the most complete inventory possible and fast same-day delivery service. Hawaii's medical profession and the people of our state deserve complete, effective drug service.

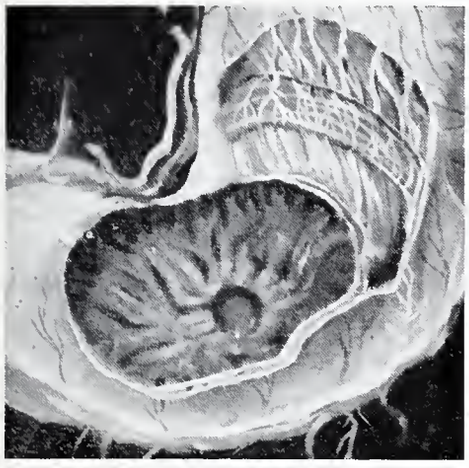
Medicine is not a cut rate field.

Charles R. Hadley
*MANAGER*

John G. Kawafuchi
*SALES MANAGER*

**AMFAC INC DRUG DEPARTMENT**

# In peptic ulcer... antacid therapy with a new benefit



CONTAINS A BALANCED COMBINATION OF THE MOST WIDELY USED ANTACIDS— FOR RAPID NEUTRALIZATION. PLUS SIMETHICONE— TO CONTROL THE FACTOR WHICH ANTACIDS ALONE CANNOT INFLUENCE.

# Mylanta®

- In Mylanta, aluminum and magnesium hydroxides are balanced to minimize the chance of constipation or laxation and still achieve rapid acid neutralization and pain relief.
- The positive action of simethicone helps relieve the painful gas symptoms which often accompany the peptic ulcer syndrome.
- The nonfatiguing flavor and smooth, nongritty consistency of tablets and liquid encourage continued patient cooperation during long-term therapy.

**Composition:** Each Mylanta chewable tablet or teaspoonful (5 ml.) of liquid contains: magnesium hydroxide, 200 mg.; aluminum hydroxide, dried gel, 200 mg.; simethicone, 20 mg. **Dosage:** one or two tablets, well chewed or allowed to dissolve in the mouth, or one or two teaspoonfuls of liquid to be taken between meals and at bedtime.

**The Stuart Company,** Pasadena, California
Division of Atlas Chemical Industries, Inc.

Stuart



# Preludin®
henmetrazine
ydrochloride





# helps keep calories at arm's length

one double-blind program* volving diet, close doctor/patient operation, exercise, posture struction, and follow-up visits, 93 ese patients received Preludin or placebo. The drug and placebo were ternated every four weeks. This ocedure lasted from 8 to 35 weeks.

xty-one percent of the patients st more weight on Preludin an on placebo. In fact, they lost n average 1.9 pounds per week—almost four times as much as when they were on placebo!

For a decade Preludin has demonstrated similar results. Its effectiveness has been described in more than 300 published clinical reports involving more than 10,000 patients.

Preludin curbs appetite without excessive stimulation. It will work in your weight-control programs too.

*Barnes, R. H.: J.A.M.A. 166:898, 1958.

eludin® tablets of 25 mg.
durets® prolonged-action tablets of 75 mg.
*sage:* One 25 mg. tablet two or three times daily, one 75 mg. Endurets tablet once daily.
*ntraindications:* Severe coronary artery disease, perthyroidism, severe hypertension, nervous tability, and agitated prepsychotic states. Do use with other CNS stimulants, including AO inhibitors.
*rning:* Do not use during the first trimester of egnancy unless potential benefits outweigh ssible risks.
*ecautions:* Use with caution in *moderate* hypersion and cardiac decompensation. Excessive use may result in a psychotic illness manifested by restlessness, mood or behavior changes, hallucinations, or delusions.
*Side Effects:* Dryness or unpleasant taste in the mouth, urticaria, and (rarely) overstimulation, insomnia, dizziness, nausea, or headache.

For details, see full Prescribing Information. 6544-III (B)

Under license from Boehringer Ingelheim G.m.b.H.

Geigy
Geigy Pharmaceuticals
Division of Geigy Chemical Corporation, Ardsley, N.Y.




Tareyton...with the taste worth fighting for

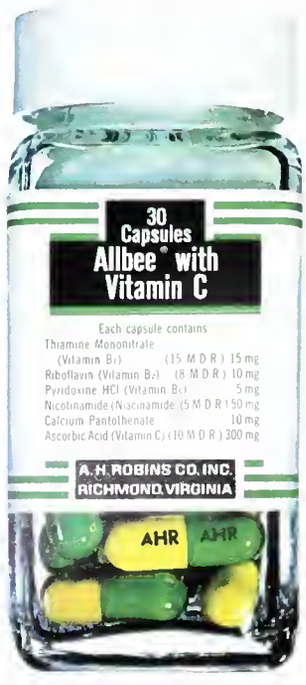
America's largest-selling charcoal-tip cigarette

©The American Tobacco Company

# Two ways to give your patients a month's therapeutic supply of vitamin C:



## 118 grapefruit or 30 Allbee® with C




Your patient would have to eat 118 medium-sized grapefruit (almost 4 a day!) to get as much vitamin C as is provided in just one bottle of 30 Allbee with C capsules (taken one capsule daily). In addition, each capsule supplies full therapeutic amounts of the B-complex vitamins.

Your patients can purchase Allbee with C capsules in the convenient bottle of thirty—a month's supply at a very reasonable price. Also the economy size of 100. Available at pharmacies everywhere on your prescription or recommendation.

A·H·ROBINS

A. H. Robins Company, Richmond, Virginia




# the spasm reactors your practice deserve

# "the Donnatal® Effect"

| | each tablet, capsule or 5 cc.of elixir (23% alcohol) | each Extentab® |
|---|---|---|
| hyoscyamine sulfate | 0.1037 mg. | 0.3111 mg. |
| atropine sulfate | 0.0194 mg. | 0.0582 mg. |
| hysocine hydrobromide | 0.0065 mg. | 0.0195 mg. |
| phenobarbital | (¼ gr.) 16.2 mg. | (¾ gr.) 48.6 mg. |
| (Warning: may be habit forming) | | |

***Brief summary.*** Blurring of vision, dry mouth, difficult urination, and flushing or dryness of the skin may occur on higher dosage levels, rarely on usual dosage. Administer with caution to patients with incipient glaucoma or urinary bladder neck obstruction. Contraindicated in acute glaucoma, advanced renal or hepatic disease or a hypersensitivity to any of the ingredients.

A. H. ROBINS COMPANY, RICHMOND, VIRGINIA 23220

A·H·ROBINS

# Blood-glucose screening for all your patients?

because "Abnormalities of glucose etabolism are among the [most ommon] encountered in clinical ractice...."* Simple, quick, economal blood-glucose screening ith DEXTROSTIX® Reagent Strips is racticable in every regular physical xamination, emergency situation, nd whenever hypo- or hyperlycemia may be of clinical ignificance—for "The precision nd accuracy of DEXTROSTIX ..meet the need for an always vailable simple screening ethod...."* All that is required or screening with EXTROSTIX is 60 seconds nd a globular drop of apillary or venous blood. Abnormal readings will be a valuable aid to diagnosis; ormals will help you stablish an important aseline for future reference.

Marks, V., and Dawson, A.: Brit. M. J. *1*:293, 1965.



**DEXTROSTIX—**
provides a clinically useful determination when performed according to directions†

†DEXTROSTIX is not intended to replace the more precise analytical laboratory methods.

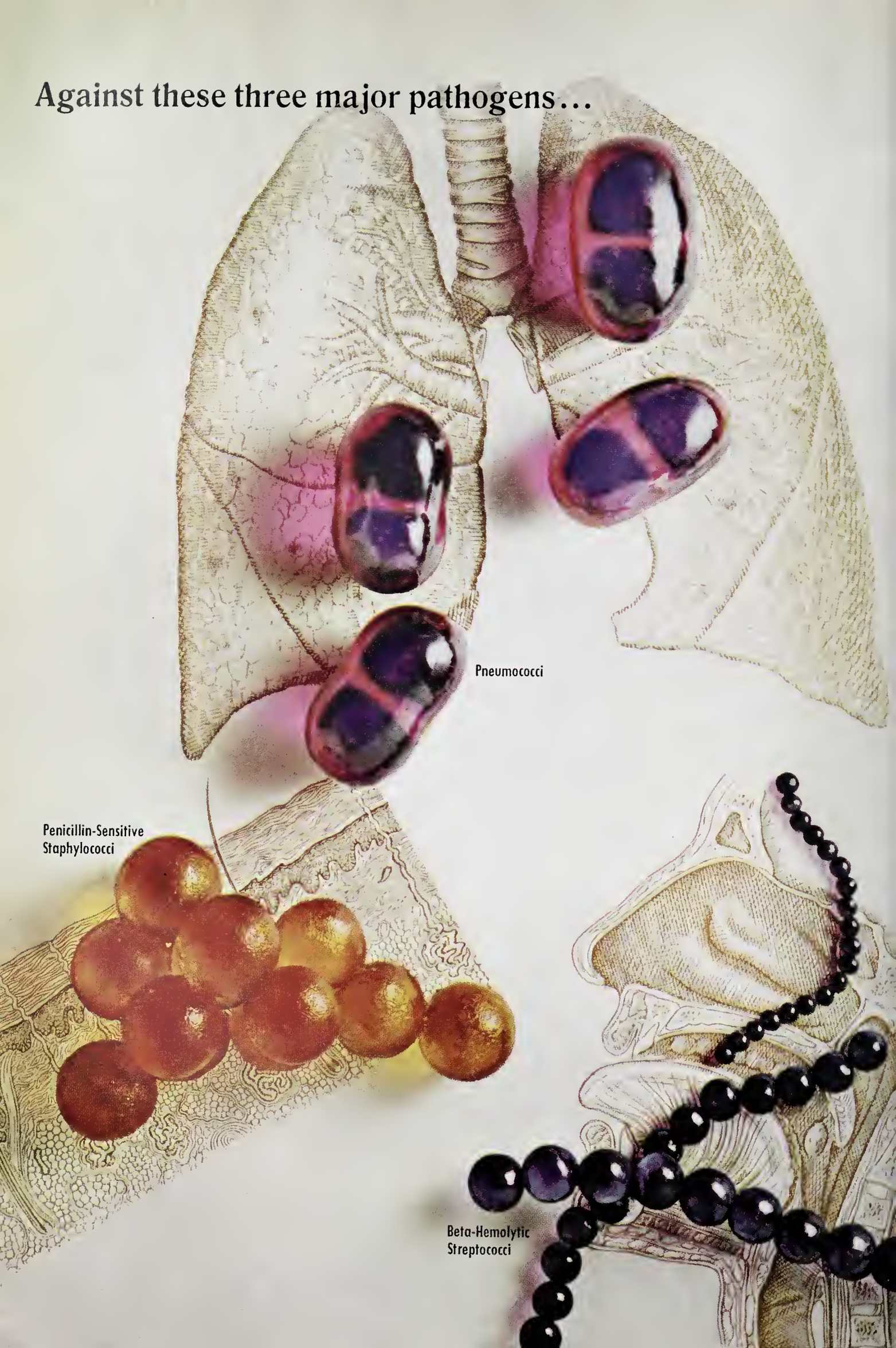
# Yes—all your patients

AMES COMPANY, INC.
Elkhart, Indiana

AMES

09165

# Against these three major pathogens…



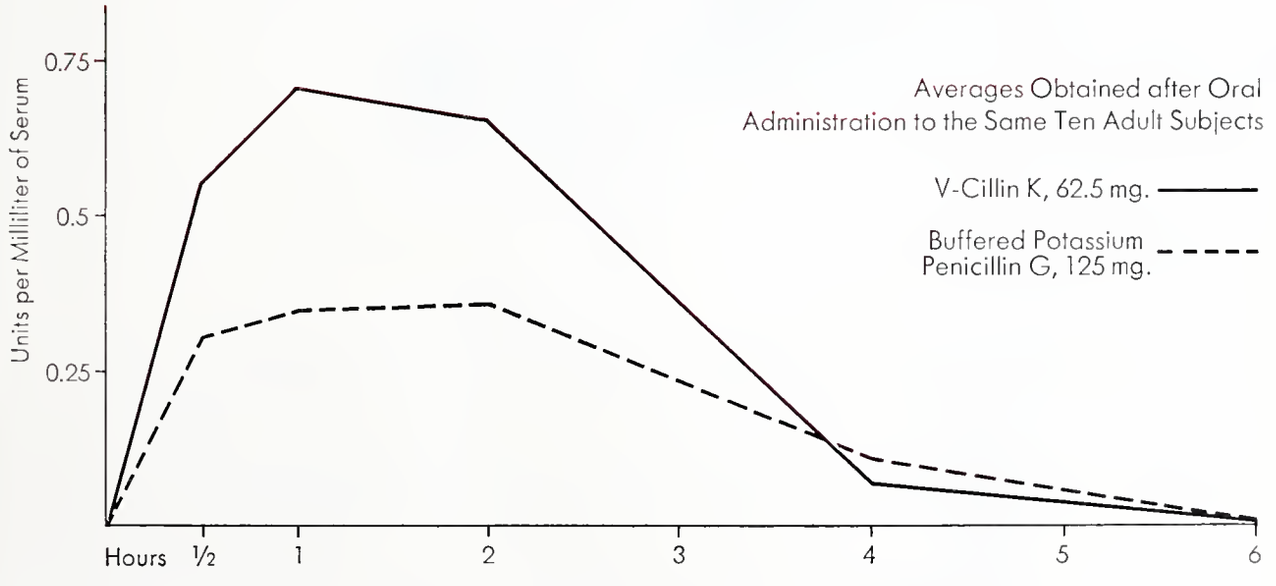
# V-Cillin K® provides unexcelled oral antibacterial activity

## because it combines a high degree of in-vitro activity...

| Antibiotic | Staph. Aureus (Penicillin-Sensitive) MIC (mcg./ml.) Median | Range | Streptococcus, Graup A MIC (mcg./ml.) Median | Range | Diplacaccus Pneumaniae MIC (mcg./ml.) Median | Range |
|---|---|---|---|---|---|---|
| Penicillin V | 0.02 | 0.02-0.04 | 0.02 | 0.003-0.4 | 0.01 | 0.005-0.2 |
| Penicillin G | 0.02 | 0.005-1.6 | 0.005 | 0.002-0.2 | 0.02 | 0.01-0.1 |
| Methicillin | 1.6 | 0.4-6.3 | 0.2 | 0.1-0.4 | 0.2 | 0.1-1.6 |
| Oxacillin | 0.4 | 0.1-3.1 | 0.04 | 0.02-0.4 | 0.1 | 0.04-0.8 |
| Cloxacillin | 0.2 | 0.2-0.8 | 0.1 | 0.1-0.8 | — | — |
| Nafcillin | 0.4 | 0.2-0.8 | 0.04 | 0.02-0.1 | 0.02 | 0.02-0.2 |
| Ampicillin | 0.2 | 0.1-0.8 | 0.02 | 0.01-0.04 | 0.02 | 0.01-0.04 |

Adapted from Klein, J. O., and Finland, M.: New England J. Med.,269 1019, 1963.

## with high blood levels, even in the presence of food



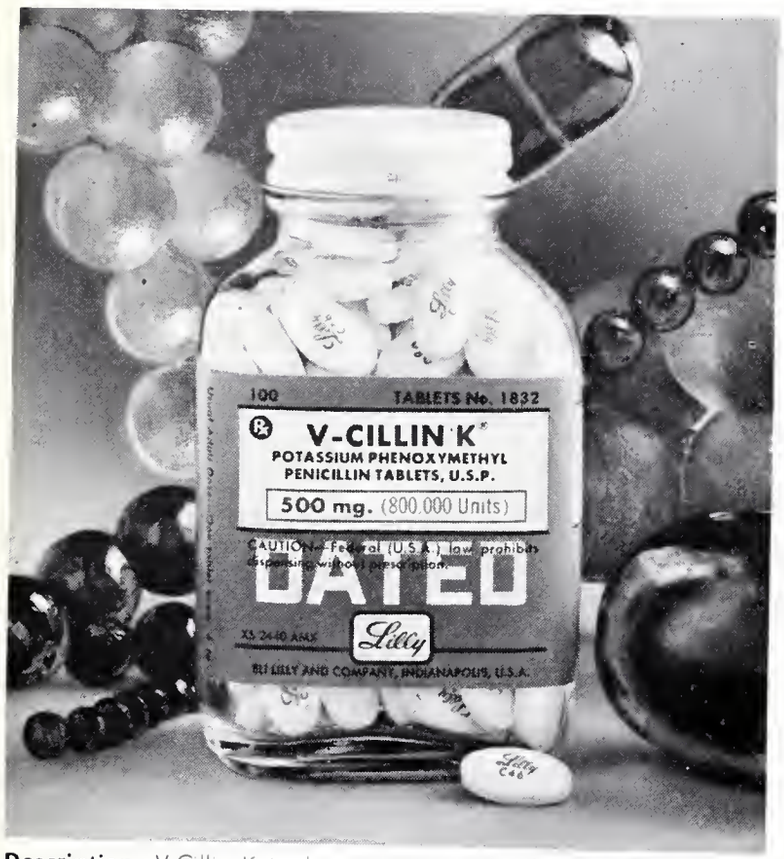

Adapted from Griffith, R. S., and Black, H. R.: Current Ther. Res., 6 253, 1964.

**V-Cillin K®** Lilly 700157

**Potassium Phenoxymethyl Penicillin**

*(See next page for prescribing information.)*

# New 500 mg. tablets...a more convenient way to give high doses




**Description:** V-Cillin K is the potassium salt of V-Cillin® (phenoxymethyl penicillin, Lilly). This chemically improved form combines acid stability with immediate solubility and rapid absorption. Higher serum levels are obtained more rapidly with this penicillin than with equal oral doses of penicillin G. The higher serum levels and acid stability of V-Cillin K make it a more dependable penicillin for oral use.

V-Cillin K, Pediatric, is an oral solution of clinically proved V-Cillin K in teaspoon dosage form. When mixed as directed, each 5 cc. (approximately one teaspoonful) will contain 125 mg. (200,000 units) phenoxymethyl penicillin as the potassium salt.

**Indications:** V-Cillin K has been shown to be effective in the treatment of streptococcus, pneumococcus, and gonococcus infections as well as infections caused by sensitive strains of staphylococci. It may be used for the prophylaxis of streptococcus infections in patients with a history of rheumatic fever and for the prevention of bacterial endocarditis after tonsillectomy and tooth extraction in those potients with a history of rheumatic fever or congenital heart disease.

**Contraindication:** V-Cillin K should not be administered to a patient with a history of penicillin hypersensitivity.

**Precautions:** V-Cillin K should be used cautiously, if at all, in a patient with a strongly positive history of allergy. Reactions occur more frequently in individuals with bronchial asthma or other allergies or in those who have previously demonstrated sensitivity to penicillin. If hypersensitivity reactions occur, the drug should be discontinued.

**Adverse Reactions:** Although serious allergic reactions are much less common with administration of oral penicillin than with intramuscular forms, skin rash, symptoms resembling those of serum sickness, or other manifestations of penicillin allergy may occur. When penicillin is administered, measures for treating anaphylaxis should be readily available. Those include epinephrine, oxygen, and pressor drugs for relief of immediate allergic manifestations as well as antihistamines and corticosteroids for delayed effects.

The use of antimicrobial agents may be associated with the overgrowth of antibiotic-resistant organisms; in such a case, antibiotic administration should be stopped and appropriate measures taken.

**Administration and Dosage:** For Tablets V-Cillin K and for V-Cillin K, Pediatric, the usual dosage ranges from 125 mg. (200,000 units) three times a day to 500 mg. (800,000 units) every four hours. For infants, the daily dosage may be 50 mg. per Kg. of body weight divided into three doses.

Beta-hemolytic streptococcus infections without associated bacteremia may be treated with 200,000 to 400,000 units three times a day. Therapy should be continued for a minimum of ten days to prevent development of rheumatic fever and/or other serious complications. Dosage for routine streptococcus prophylaxis in patients with a history of rheumatic fever or congenital heart disease may be 200,000 units once or twice daily. When such patients undergo tonsillectomy, tooth extraction, or other minor surgery, the prophylactic dose should be 500,000 units every six hours given two days prior to surgery and for two days postoperatively. If oral medication is not feasible on the day of surgery, parenteral therapy should be considered. Mild to moderately severe pneumococcus pneumonia has been treated effectively with 250 mg. every six hours.

In staphylococcus infections, 400,000 units or more should be given every six to eight hours in conjunction with indicated surgical procedures.

For gonorrhea in males, 500 mg. (800,000 units) every six hours for three doses may be employed; in females, 500 mg. every four hours for six doses are recommended. Patients with a suspected lesion of syphilis should have a dark-field examination before receiving penicillin and monthly serologic tests for a minimum of three months.

**How Supplied:** Tablets V-Cillin K, U.S.P., 125 mg. (200,000 units), in bottles of 50 and 100; 250 mg. (400,000 units), and 500 mg. (800,000 units) in bottles of 24 and 100.

V-Cillin K, Pediatric, for Oral Solution, 125 mg. (200,000 units) per 5 cc. of solution, in 40, 80, and 150-cc.-size packages.

*Additional information available to physicians upon request. Eli Lilly and Company, Indianapolis, Indiana 46206.*

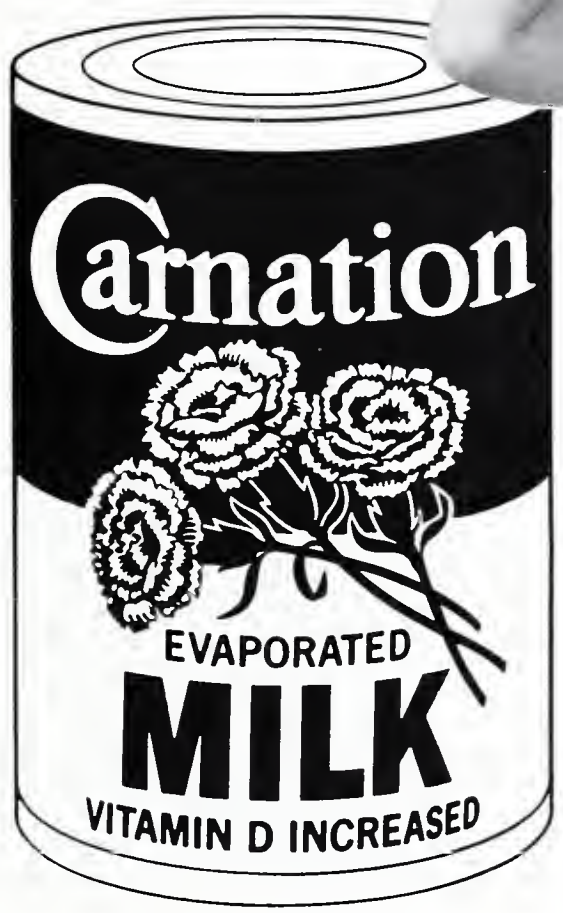
Lilly

700157

# Carnation

EVAPORATED MILK

## HAWAII'S HEALTHY BABY MILK...





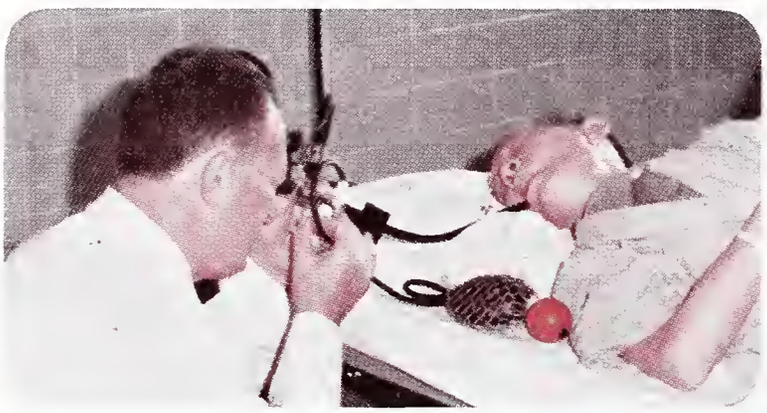

*"from Contented Cows"*

***1st CHOICE FOR INFANT FEEDING...***
***No. 1 in the Islands for generations,***
***...available everywhere in Hawaii***

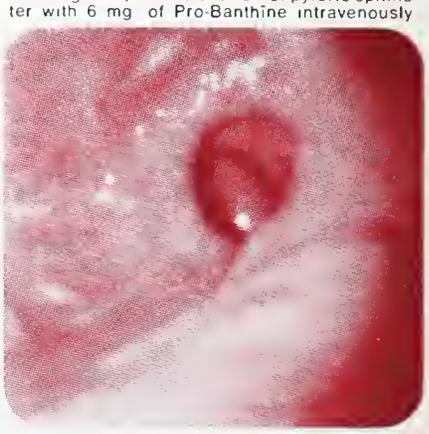
1966
Carnation Healthy Baby Contest
$1,000 1st prize winner,
Peter David Keaomalamalama Yoshimi Malo
of Honolulu, Hawaii

NEW EVIDENCE:

**Pro-Banthine®** (propantheline bromide)
**gives positive, selective benefits in gastrointestinal disorders.**



Intragastric photograph of pyloric region showing complete relaxation of pyloric sphincter with 6 mg of Pro-Banthine intravenously



AN IMPORTANT PROBLEM in managing gastrointestinal disorders has been the choice of an anticholinergic agent which will act positively and selectively on the gastrointestinal tract without extensive secondary effects.

Recent direct observations with the cinefibergastroscope and intragastric photography[1] visually confirm previous evidence that Pro-Banthine does, indeed, possess such selective activity.

Barowsky and his associates demonstrated that a minimal dose of 6 to 8 mg. of Pro-Banthine intravenously produced complete relaxation of gastric activity. Secondary effects were not significant.

By contrast, it required 0.8 mg. or double the usual dose of atropine intravenously to achieve similar gastric relaxation. Side effects of this dosage of the belladonna alkaloid were pronounced. Ventricular rates were as high as 150 per minute.

For positive, selective anticholinergic benefits Pro-Banthine is indicated in patients with peptic ulcer, gastritis, irritable colon and other forms of gastrointestinal hypermotility.

**Dosage:** The maximal tolerated dosage is usually the most effective. For most *adult* patients this will be four to six 15-mg. tablets daily in divided doses. In severe conditions as many as two tablets four to six times daily may be required. Pro-Banthine (brand of propantheline bromide) is supplied as tablets of 15 mg., as prolonged-acting tablets of 30 mg. and, for parenteral use, as serum-type ampuls of 30 mg. The parenteral dose should be adjusted to the patient's requirement and may be up to 30 mg. or more every six hours, intramuscularly or intravenously.

**Contraindications:** In glaucoma or severe cardiac disease.

**Precautions:** Since varying degrees of urinary hesitancy may occur in the elderly male with prostatic hypertrophy, this should be watched for in such patients until they have gained some experience with the drug.

Although never reported, theoretically a curare-like action may occur with possible loss of voluntary muscle control. Such patients should receive prompt and continuing artificial respiration until the drug effect has been exhausted.

**Side Effects** The more common side effects, in order of incidence, are xerostomia, mydriasis, hesitancy of urination and gastric fullness.

1. Barowsky, H.; Greene, L.; Bennett, R., and Buganza, G.: The Effect of Anticholinergic Drugs on Gastric Motility and Pyloric Function, Scientific Exhibit, Annual Convention of the American Medical Association, Chicago, Illinois, June 26-30, 1966.

SEARLE *Research in the Service of Medicine*



Photo professionally posed

# Mike expects a penicillin injection. He's about to be pleasantly surprised.

His physician is going to prescribe an oral penicillin —PEN•VEE® K (potassium phenoxymethyl penicillin). It's usually so rapidly and completely absorbed that therapeutic serum levels are produced in 15 to 30 minutes. Higher serum levels generally last longer than with oral penicillin G.

**Indications:** Infections due to pathogens susceptible to oral penicillin G. Prophylaxis of rheumatic fever in patients with previous history of the disease.

**Precautions:** Skin rash, symptoms resembling those of serum sickness, or other manifestations of penicillin-allergy may occur. Measures for treating anaphylaxis should be readily available: epinephrine, oxygen and pressor drugs for relief of immediate allergic reactions; antihistamines and corticosteroids for delayed effects. Penicillin may delay or prevent the appearance of primary syphilitic lesions. Patients with gonorrhea who are suspected of concurrent syphilitic infections should be tested serologically for at least 3 months. Where lesions of primary syphilis are suspected, dark-field examination should precede use of penicillin. As with other antibiotics overgrowth of nonsusceptible organisms may occur; if so, discontinue and take appropriate measures. Treat β-hemolytic streptococcal infections with full therapeutic dosage for at least 10 days to prevent development of rheumatic fever or glomerulonephritis.

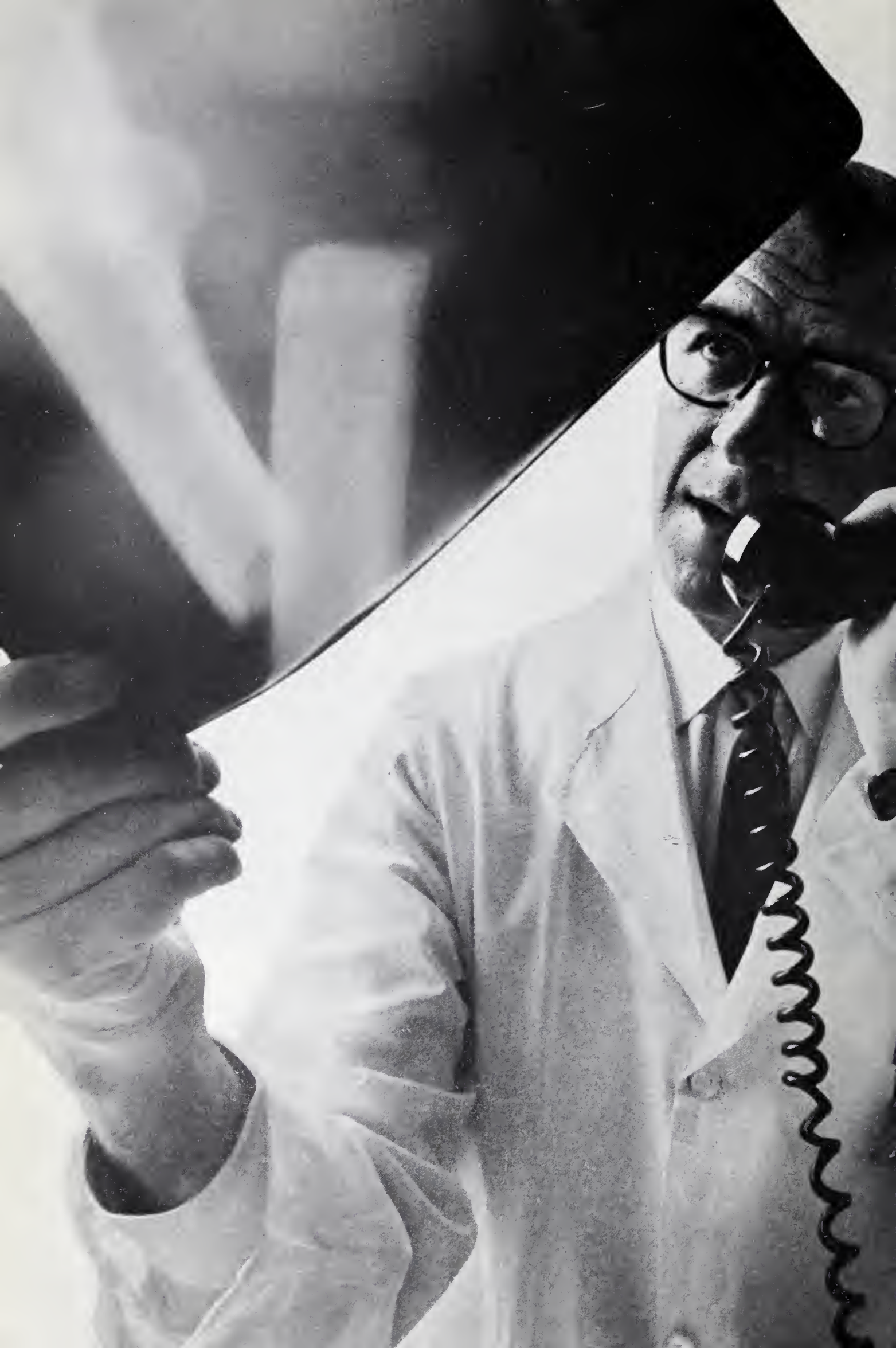
**Contraindications:** Infections caused by nonsusceptible organisms; history of penicillin sensitivity.

**Composition:** Tablets—125 mg. (200,000 units) and 250 mg., (400,000 units); Liquid—125 mg. (200,000 units) and 250 mg. (400,000 units) per 5 cc.

Wyeth Laboratories Philadelphia, Pa.

ORAL **PEN•VEE® K**

**(potassium phenoxymethyl penicillin)** Wyeth®





# Want it to go like 90?

Now almost any Kodak X-omat Processor can be converted to 90-second operation. And in a remarkably short time. And at very low cost. Here's how easy it really is. If you now use an X-omat Processor, Model M4, M4A, or M4B, all you need do is call your Kodak X-omat dealer or Technical Sales Representative.

Own an M5? No problem. We'll exchange it for a factory-converted model. And M3 Processors can be converted to 180-second operation.

If you don't now use an X-omat Processor of any kind, let our representative show you the dramatic new Kodak RP X-omat Processor, Model M6, the first automatic processor designed exclusively for 90-second processing.

Processing in 90 seconds means rapid access to critical radiographs and less patient waiting. You can serve more people in a shorter time.

And the new 90-second Kodak Rapid Processing System, with its two films, gives clean, brilliant radiographs of high diagnostic readability. If time is a factor in your practice, isn't this the time to investigate the Kodak Rapid Processing System?

**EASTMAN KODAK COMPANY**
**Radiography Markets Division**
**Rochester, New York**

Kodak
TRADEMARK



*"Wine is constant proof that God loves us and loves to see us happy"*

—BENJAMIN FRANKLIN



**DEAR DOCTOR:**

Ben was right, Doctor, as usual. The warm California sunshine that blesses our vineyards becomes, for you, a glass of happiness and good fellowship. Try a bit of wine with your dinner tonight.

Especially if you go home tired and tense. Because as a physician you know, Doctor, how wine can help relieve tension; is euphoric for the elderly patient and serves as a source of energy; goes well with many prescribed diets in diabetes and cardiovascular disease.

Speaking of patients, we'd like to send you, free, the 64-page booklet, "USES OF WINE IN MEDICAL PRACTICE," newly revised. It summarizes the findings of a quarter century of scientific research on this subject in America and Europe. We believe you will find it useful in your practice.

We'd also like to send you (to make your wife's menu planning easier, and your meals more delicious), our free 24-page booklet, "WINE COOKERY—THE EASY WAY."

Just drop us a note for these two free booklets. And here's a California toast to your own health, Doctor, with wine... *"¡Salud!"*

The Winemakers of California

WINE ADVISORY BOARD, 717 MARKET ST., DEPT. 3, SAN FRANCISCO, CALIF. 94103

# People keep asking us:

*"Why do you call the*

**FILTER QUEEN**

*a sanitation system*

*instead of a vacuum cleaner?"*




FOR THE BIG DIFFERENCE
SEE THE NEXT TWO PAGES

# Only FILTER

(The problem of overcoming increasing air pollution is one of the most urgent facing your institution and the entire comm
today. How FILTER QUEEN, through its unique, patented Filter Cone helps combat air pollution while it cleans, shoul
of vital interest to every member of your hospital staff. We hope you will mark these pages and route them accordin



1. Every hospital has its dust and odor problems.

## Dramatic smoke test shows how FILTER QUEEN removes air-borne contaminants and offensive odors



2. That's when a FILTER QUEEN is needed.



3. FILTER QUEEN quickly removes air-borne contaminants while it vacu

# QUEEN helps purify he air while it cleans!

## at is why we call FILTER QUEEN sanitation system instead of a vacuum cleaner!

**EW OF THE HUNDREDS OF HOSPITALS NOW USING FILTER QUEEN:**

| | |
|---|---|
| Community Hospital | Fresno, California |
| Memorial Hospital | Atlanta, Georgia |
| Hospital | Columbus, Ohio |
| County General Hospital | Paris, Tennessee |
| Ford Hospital | Detroit, Michigan |
| oss Hospital | Ft. Lauderdale, Florida |
| geles City Genl. Hospital | Los Angeles, California |
| Memorial Hospitals | Boston, Massachusetts |
| l College of Virginia | Richmond, Virginia |
| estern Hospital | Minneapolis, Minnesota |
| k Hospital | Summit, New Jersey |
| uron Hospital | Port Huron, Michigan |
| s Hospital | Honolulu, Hawaii |
| n's Memorial Hospital | Anderson, Indiana |
| ter City Hospital | Worcester, Massachusetts |

The engineers who perfected the FILTER QUEEN machine clearly recognized that all bag-type vacuum cleaners cannot operate with maximum efficiency because they use a porous bag. So, to make suction cleaning action truly efficient, they had to find a way to overcome the leakage in dust and dirt that so often occurs whenever a porous bag is used.

The highly successful result was an entirely *different* air flow principle, known today as Cyclonic Cleaning Action. By using Cyclonic Cleaning Action, FILTER QUEEN'S designers succeeded in not only collecting the dust and dirt normally collected by vacuuming; they also succeeded in trapping almost invisible airborne contaminants that formerly escaped back to repollute the air.

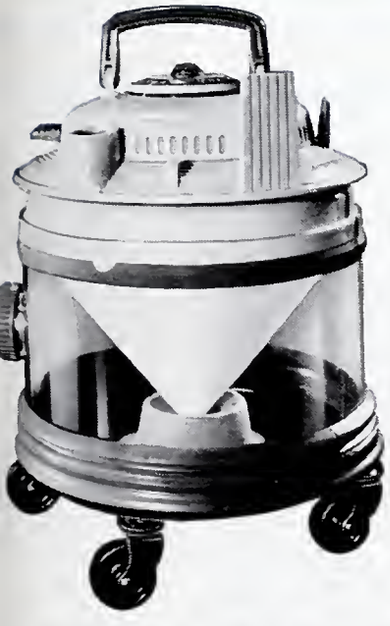
The difference between FILTER QUEEN'S remarkable Cyclonic Cleaning Action and ordinary vacuuming becomes immediately apparent when the Smoke Test pictured at left is made. Smoke, other contaminants and offensive odors virtually disappear. The room not only smells clean—it *is* clean!

The key to this almost magic action is FILTER QUEEN'S patented Sanitary Filter Cone. (See illustration.) Inrushing air, laden with dirt and dust, is deflected by a patented inlet guide as it enters the FILTER QUEEN container, then is whirled away by centrifugal force. Foreign matter heavier than air is forced to the bottom and the sides.

Clean air is filtered through our exclusive Sanitary Filter Cone *above* floor level, leaving smoke as well as dirt and dust trapped in the container. That is why hundreds of hospitals and other institutions insist on the FILTER QUEEN Sanitation System over any type of vacuum cleaner.

Ask your local FILTER QUEEN Distributor to make FILTER QUEEN'S dramatic Smoke Test in your hospital. Then you will *KNOW* why we proudly call it a FILTER QUEEN Sanitation System instead of a "vacuum cleaner."

**DOCUMENTARY PROOF:** *We would like to send you, with our compliments, an article entitled "Air Hygiene for Hospitals" which appeared in the Journal of the American Medical Association. In this article it is explained what happened to airborne contaminants when a FILTER QUEEN was used in a series of rigidly controlled tests conducted at the Harvard Medical School. Write to Health-Mor, Inc., 203 North Wabash Ave., Chicago, Illinois 60601*



The FILTER QUEEN sanitary filter cone is a scientifically-designed dust separator, composed of a special long-fibred mat of pure cellulose, chemically treated to give it the necessary strength and air-filtering characteristics.

FILTER QUEEN is a product of HEALTH-MOR, INC.,
203 North Wabash Ave., Chicago, Ill. 60601.
*In Canada:* Filter Queen Corp. Ltd.,
252 Victoria St., Toronto, Ont.
*In Mexico:* Industrias Filter Queen, S. A.,
Jardin No. 330, Col del Gas, Mexico 15, D. F.

You'll find FILTER QUEEN Sanitation Systems listed in your Yellow Pages under "Vacuum Cleaners". (That's because FILTER QUEEN is fast replacing ordinary vacuum cleaners.)



# FILTER QUEEN

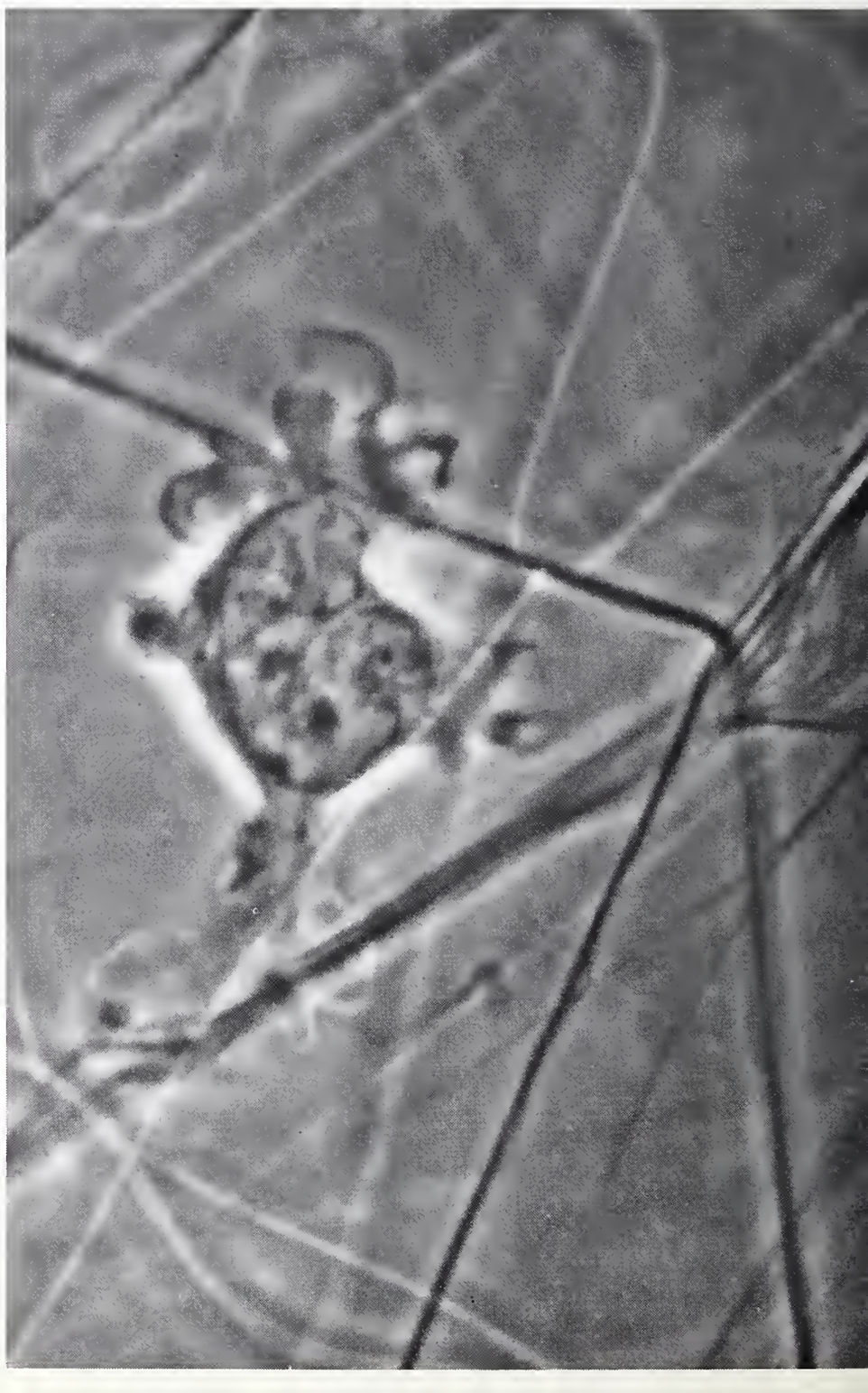
*The cleaning method that does so much more it has to be called a Sanitation System.*

# INFLAMMATION:
# A cellular fight for life

*A SYNTEX REPORT based on recently developed hypotheses about topical corticosteroids, including the cellular theories of inflammation by Thomas F. Dougherty, Ph.D., University of Utah.*

You are looking at a fibroblast fighting for life. This cell—one of the most common found in connective tissue—has literally been poisoned by cytotoxins released from other cells that have ruptured. Soon, if the abnormal activity of this fibroblast does not cease, it, too, will rupture and die—one more casualty in the inflammatory wave of destruction precipitated by injury.

Until a short time ago no one had ever witnessed such a scene at the cellular level. Now, through advanced cinemicrographic techniques, it is possible to view and photograph the inflammatory process as produced experimentally in living animal tissue. This method permits new insight into the mechanism of inflammation and the role of corticosteroids in therapeutic management. Equally important, these techniques shed new light on factors that may make one corticosteroid more effective than another—factors that can be correlated with other chemical, biologic, and clinical parameters.

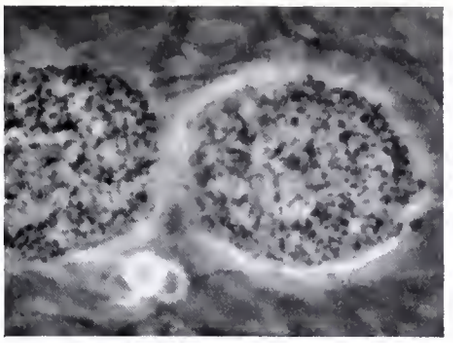


## Visual evidence of how corticosteroids influence the inflammatory reaction

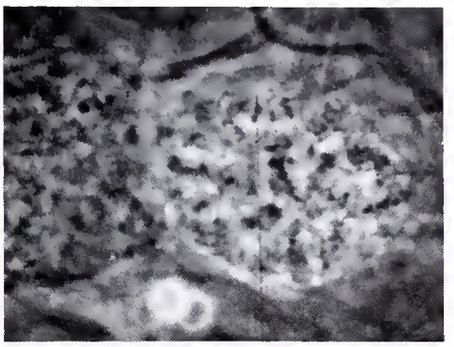
Working with phase-contrast cinemicrography on living animal tissue, Doctors Thomas F. Dougherty and David Berliner of the University of Utah College of Medicine have actually filmed cellular events that occur during the inflammatory reaction. This remarkable study* and additional work by these investigators, as well as by others, have established a new theoretical biologic basis for the antiinflammatory effect of the corticosteroids. (It must be noted that other theories, such as the lysosome or so-called "suicide bag" theory, have been postulated, although it is quite likely that there are more similarities than differences among the various theoretical models.)

## The inflammatory wave of destruction

In this investigation an injurious injection of gelatin is used to set off an inflammatory reaction in living mouse tissue. What follows is a wave of destructive cellular activity that comprises the inflammatory response to injury. Mast cells (which contain heparin, serotonin and histamine) take up water, swell and rupture, releasing their contents, which are toxic outside the mast cell wall. These toxins, in turn, cause disintegration of other cells (such as fibroblasts) and the release of additional toxic material. Capillaries, too, take up water and leak unformed blood elements, causing edema. And polymorphonuclears, lymphocytes and perithelial cells invade the inflamed site. As a result of all these changes, the cellular environment reaches a state of turmoil.



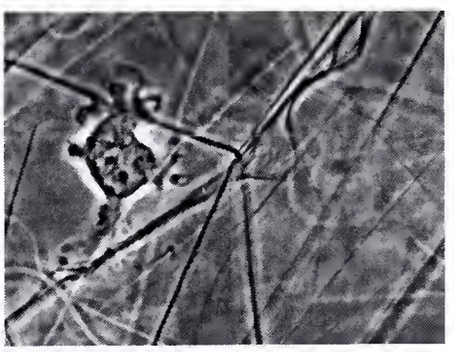
*Phase-contrast microscopy showing mast cell before injury.*



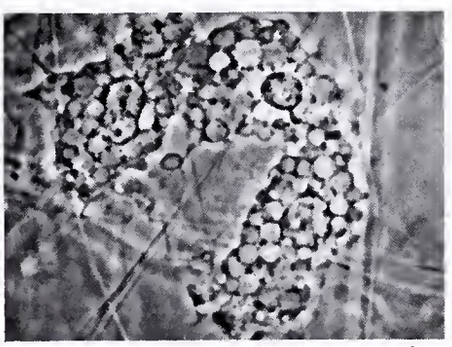
*Mast cell (after injury) has broken up and released cytotoxins.*

## How corticosteroids change the picture

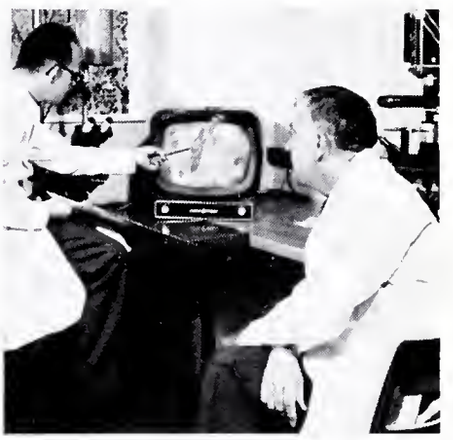
Corticosteroids appear to virtually stop the abnormal cellular activity that constitutes the inflammatory reaction. This permits the body's natural resources to clear up the inflamed area and repair the damaged tissue. This interpretation is supported by the fact that when the injurious gelatin solution is injected simultaneously with a corticosteroid – Synalar (fluocinolone acetonide) – the inflammatory pattern simply does not develop.



*Fibroblast in high state of activity, much distorted.*



*Mast cells showing effects of corticosteroid action: cells are normal in size, shape and activity.*



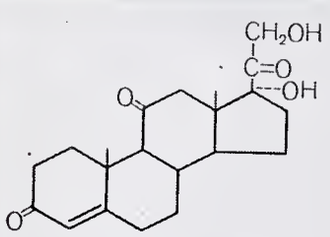
In summarizing his study Doctor Dougherty states: "...we also feel this work may explain why one corticosteroid helps a patient more rapidly and effectively than another. If it does, it is because one corticosteroid is the fastest, most effective inhibitor of the series of inflammatory events at the tissue level."

**A New View of Corticosteroid Action in Inflammatory Dermatoses,* a film based on this study, is now available from your Syntex representative.

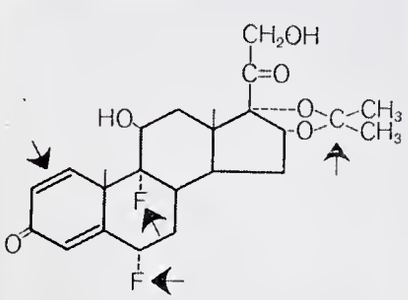
*See last page for contraindications, precautions, side effects and dosage.*

# How advances in chemical design have achieved greater steroid potency

The chemical modification of corticosteroid molecules from the advent of hydrocortisone to the development of Synalar (fluocinolone acetonide) is a prime example of how biochemists can "design" to increase therapeutic activity and minimize undesirable side actions. Below, for example, we see the important changes that were made in reference to the hydrocortisone molecule to produce fluocinolone acetonide, one of the most active of all topical corticosteroids. As a result, a 0.01% preparation of Synalar (fluocinolone acetonide) has been reported to do the work of a 1% hydrocortisone product containing 100 times more cortiscosteroid. And it can often do it more effectively.




**Hydrocortisone**

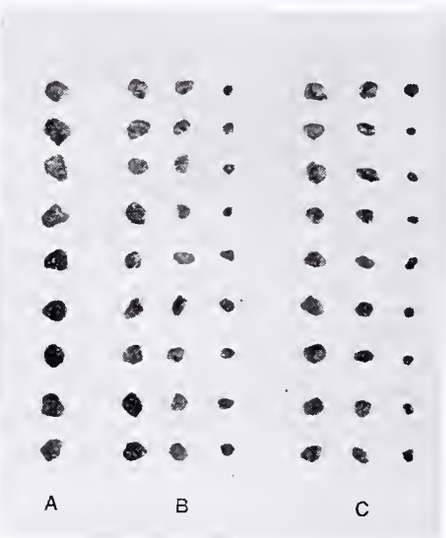



**Fluocinolone Acetonide (Synalar)**

- ☐ *a double bond between carbons 1 and 2*
- ☐ *fluorine substitutions at* both *the 6-α, and the 9-α positions*
- ☐ *the addition of the acetonide at the 16-α, 17-α positions, thus providing one of the most potent topical corticosteroids available.*

## How bioassay tests are used to "predict" therapeutic potential

Biologic assays are another tool used by researchers to help establish the relative activity of corticosteroids. To date no single method of assaying corticosteroid activity has emerged as the ideal "yardstick" for predicting therapeutic potential. Taken together, however, these methods have proved useful. When such tests are run on various corticosteroids, a definite order of corticosteroid activity becomes evident. Compounds with the highest order of activity may be expected to merit clinical trial to establish their high therapeutic potential. When assayed by these methods, fluocinolone acetonide (Synalar) emerges as one of the most active topical corticosteroids, milligram for milligram, available for clinical application today.




THE THYMUS INVOLUTION ASSAY[1-4] is run on adrenalectomized rats. The sizes of the glands are measured, and the degree of involution caused by the steroid is determined as an indication of its potency. In the above photo, the comparative involution of thymus glands achieved with hydrocortisone and Synalar (fluocinolone acetonide) is shown. Untreated controls (A) show normal size. Group B – injected with 1, 2 and 4 mg. of hydrocortisone – show progressively smaller thymuses as does Group C – injected with fluocinolone acetonide – but with only 1/500th the dose of hydrocortisone.




THE ANTIGRANULOMA ASSAY[1-4] also utilizes adrenalectomized rats. Granulomas are induced by subcutaneous implantation of cotton pellets on either side of the thorax. The degree of granuloma inhibition achieved by a steroid reflects its potency. The above photo shows the inhibition of granuloma formation achieved with hydrocortisone and Synalar (fluocinolone acetonide). Untreated controls (A) show large, red granulomas adhering to the pellets. Group B, receiving hydrocortisone and Group C, receiving fluocinolone acetonide, show little, if any, granuloma formation. Fluocinolone acetonide produced the same effect as hydrocortisone with only 1/500th the dose. This assay, as well as the thymus involution assay, measures systemic rather than topical corticosteroid activity. Nevertheless, results by these methods correlate well with other assays and with the milligram potencies of topical steroids in current clinical use.

# Worldwide clinical experience confirms the predictable therapeutic potential of Synalar

It is particularly gratifying that the promise of the advanced chemical design and high order of bioassay activity of Synalar (fluocinolone acetonide) has been confirmed by widespread therapeutic application. Indeed, the impressive clinical response rate of Synalar has been documented in no fewer than 232 papers from 22 countries.

**Representative Clinical Results with Synalar***

**Efficacy Documented in over 4,000 Patients**

| Condition | Number of Publications | Number of Patients | Significant Improvement† |
|---|---|---|---|
| Contact Dermatitis | 27 | 750 | 713 |
| Eczematous Dermatitis | 21 | 472 | 409 |
| Seborrheic Dermatitis | 18 | 442 | 426 |
| Atopic Dermatitis | 24 | 460 | 426 |
| Psoriasis | 36 | 1,699 | 1,510 |
| Neurodermatitis | 18 | 351 | 324 |
| Total | 144 | 4,174 | 3,808 |

*Complete bibliography on request.

†Expressed by the authors as excellent, very good, good, complete remission of inflammation, etc.

PRESCRIBING INFORMATION

*For initiation of therapy:* Cream 0.025%, 5 and 15 Gm. tubes, 425 Gm. jars; *for emollient effect:* Ointment 0.025%, 15 Gm. tubes; *for maintenance therapy:* Cream 0.01%, 15 and 45 Gm. tubes, 120 Gm. jars; *for intertriginous or hairy sites:* Solution 0.01%, 20 cc. and 60 cc. plastic squeeze bottles; *for infected inflammatory dermatoses:* Neo-Synalar® Cream (0.025% fluocinolone acetonide, neomycin sulfate, equivalent to 0.35% neomycin base), 5 and 15 Gm. tubes.

CONTRAINDICATIONS: Tuberculous, fungal, and most viral lesions of the skin, (including herpes simplex, vaccinia, and varicella). Not for ophthalmic use. Contraindicated in individuals with a history of hypersensitivity to any of the components. PRECAUTIONS: Synalar preparations are virtually nonsensitizing and nonirritating. However, the solution may produce burning or stinging when applied to denuded or fissured areas. In some patients with dry lesions, the solution may increase dryness, scaling or itching. While topical steroids have not been reported to have an adverse effect on pregnancy, the safety of their use on pregnant females has not absolutely been established. Therefore, they should not be used extensively on pregnant patients, in large amounts, or for prolonged periods of time. Prolonged use of any antibiotic may result in overgrowth of nonsusceptible organisms; if this occurs, appropriate therapy should be instituted. When severe local infection or systemic infection exists, the use of systemic antibiotics should be considered, based on susceptibility testing. SIDE EFFECTS: Side effects are not ordinarily encountered with topically applied corticosteroids. As with all drugs, however, a few patients may react unfavorably to Synalar under certain conditions. The neomycin in Neo-Synalar Cream rarely produces allergic reactions.

REFERENCES: 1. Lerner, L. J., Bianchi, A., Turkheimer, A. R., Singer, F. M., and Borman, A.: Anti-inflammatory steroids: potency, duration and modification of activities. Ann NY Acad Sci 116:1071 (Aug. 27) 1964. 2. Idem: Comparison of anti-granuloma, thymolytic and glucocorticoid activities of anti-inflammatory steroids. Proc Soc Exp Biol Med 116:385 (June) 1964. 3. Ringler, A.: Activities of adrenocorticosteroids in experimental animals and man, in Dorfman, R. I.: Methods of hormone research, New York, Academic Press, 1964. vol. III. pp. 234-280. 4. Gubersky, V. R.: To be published.

fluocinolone acetonide — an original steroid from

SYNTEX LABORATORIES INC., PALO ALTO, CALIF.

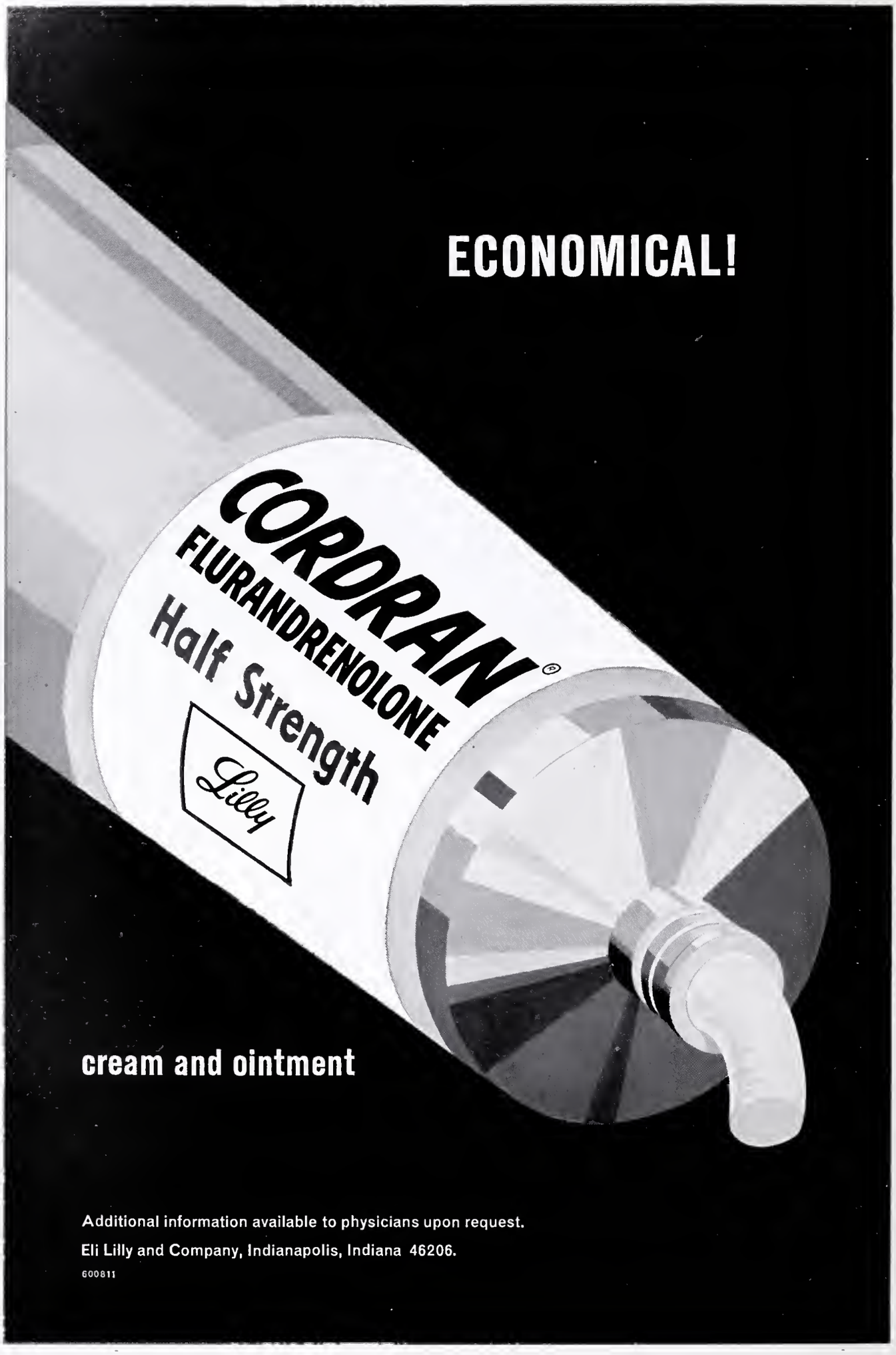
**For inflammatory dermatoses... by any measure a topical corticosteroid of choice**

# Synalar® (fluocinolone acetonide)

*Milligram for milligram one of the most active topical corticosteroids available*

*Rapid and predictable in antiinflammatory and antipruritic activity*

*Results often comparable to those of systemic corticosteroids with fewer hazards*


ECONOMICAL!
CORDRAN®
FLURANDRENOLONE
Half Strength
Lilly
cream and ointment
Additional information available to physicians upon request.
Eli Lilly and Company, Indianapolis, Indiana 46206.
600811

*The considerable complexities of an emerging group of pathogenic acid-fast bacilli are elucidated in this article.*

# Mycobacterioses: The Case Against Tradition

DRAKE W. WILL, M.D.,* *Honolulu*

• *The nontuberculous nature of a large number of pulmonary and extrapulmonary diseases caused by acid-fast mycobacteria cannot often be determined by any simpler method than culture and animal inoculation; neither clinical nor histologic criteria will permit this distinction in most cases. Antituberculous chemotherapy is often ineffective in these diseases. Awareness of the urgency of special bacteriologic studies is the key to their successful management.*

THE TERM "mycobacterioses" has been proposed recently to recognize that pulmonary and extrapulmonary tuberculous diseases may be caused by a broad variety of acid-fast bacilli.[1]

In examining this concept, the clinician's question about the nature of these diseases will elicit a response which may be misleading. The pathologist can only answer that, with a few newly-emerging exceptions, the lesions produced in lung and other tissues by non–tubercle bacilli—the unclassified mycobacteria—cannot be distinguished by present morphologic methods from lesions produced by true mammalian tubercle bacilli.

The clinician's assumption is that, if this is true, then the patient should respond to a standard treatment regimen for tuberculosis. The likelihood is that such an infection would not respond to treatment with chemotherapeutic agents effective against M. tuberculosis; in fact, it is likely that no chemotherapeutic agent would be found to be effective. Failure to respond to treatment, however, may be the first clear-cut indication that the infection is due to an acid-fast bacillus other than a true mammalian tubercle bacillus. Since the matter is not simply of academic importance, a brief review of recent work in this field may be timely.

Excluding the longest-known but still most enigmatic of all pathogenic bacteria, Mycobacterium leprae, which remains resistant to both acid-alcohol and knowledge, the mycobacteria comprise a family with (1) a wide variety of saprophytic species, occurring in soils and surface waters primarily; (2) a small number of species and strains which are obligate pathogens for warm- and cold-blooded animals; and (3) a number of intermediate species (or types) which are the unquestioned cause of disease in man and animals but are of infrequent and unexplained occurrence. Exclusive, again, of mycobacteria of no presently known importance in man, a listing and some important characteristics of each organism or type are shown in Table 1.

Laboratory diagnosis is much more complex than in the past because reliance must be placed on a variety of biochemical and cultural characteristics rather than on the results of the inoculation of guinea pigs and rabbits. The niacin test of Konno, which is positive only for the human tubercle bacillus, has relegated the guinea pig to a minor position in laboratory investigation of tuberculosis. As is seen in Table 1, differentiation of acid-fast bacilli which can be isolated from man by the use of experimental animals requires a variety of animals available only in a research vivarium. Animal studies, however, have indicated that the unclassified acid-fast bacilli have a varying and low grade pathogenicity and virulence for various species and show, in addition, certain interrelationships among the various types of organisms.

M. kansasii (photochromogens) appear to be a very distinct group of organisms, pigmenting after exposure to light and producing pulmonary disease which is often associated with severe peribronchial fibrosis and somewhat less caseation than classical tuberculosis. They show more resistance to antituberculosis agents than the true human tubercle bacillus, though the pattern of sensitivity tends to vary with the individual strain.

While Wolinsky[2] has reported some infections with scotochromogens, these ubiquitous organisms remain of questionable pathogenicity. They are the most common acid-fast bacilli in the laboratory, and have been shown to occur most often in water, where they are considered to be contaminants. Pigmenting without relation to light exposure, they do not produce disease in animals, and serve as troublesome contaminants because of confusion with M. kansasii.

The Battey type of unclassified mycobacteria has been shown by numerous workers to be related to avian tubercle bacilli. Most common in the southeastern United States, they are, nonetheless, encountered in all parts of the world. While cases of tuberculosis in man produced by M. avium are

* Department of Pathology, The Queen's Hospital.
Received for publication November 17, 1966.

TABLE 1.—*Mycobacteria producing disease in man.*

| NAME | CHARACTERISTICS | PRODUCE CHARACTERISTIC DISEASE IN | | | |
|---|---|---|---|---|---|
| | | *Chicken* | *Rabbit* | *GP* | *Mouse* |
| M. tuberculosis var. hominis | Slow growing: positive niacin test | 0 | √ | √ | √ |
| M. tuberculosis var. bovis | Slow growing: negative niacin test | 0 | √ | √ | √ |
| M. avium | Growth at 32-45° C.; slow growing | √ | √ | 0 | √ |
| M. ulcerans | Growth at 30-32° C.; slow growing | 0 | 0 | 0 | √ |
| M. xenopei | Slow growing; pigmented | √ | √ | √ | √ |
| M. marinum (balnei) | Growth at reduced temperatures only | 0 | 0 | 0 | √ |
| Unclassified mycobacteria: | | | | | |
| M. kansasii (photochromogens) | Orange-yellow pigments after light exposure | 0 | 0 | 0 | √ |
| Scotochromogens | Orange pigment without light exposure | 0 | 0 | 0 | 0 |
| M. sp. (Battey) | Moderately rapid growth | √ | √ | 0 | √ |
| M. fortuitum | Rapid growing | 0 | 0 | 0 | 0 |

uncommon, the Battey strains have become of equal interest with the photochromogens, since they are more common than was once realized. Will and Engback,[3] using avian organisms from man and fowls and a group of Battey strains, have shown patterns of virulence in animals which support the proposal that these organisms may be avian bacilli of reduced virulence for chicken and rabbits. Similar conclusions have been reached by Meissner and others,[4] using biochemical differentiation and by Scammon and her co-workers.[5] The most important aspects of Battey and M. avium infections in man are the marked lack of susceptibility to chemotherapeutic agents of all types and the high mortality of the disease in children and in adults with widespread pulmonary involvement.

Infections with fast-growing mycobacteria in man are rare. These organisms, particularly M. fortuitum, appear in three to seven days in culture and comprise a broad variety of well-known species (M. phlei, M. smegmatis, etc.) and many lesser-known organisms of similar type. They are difficult to differentiate bacteriologically but are distinguished, like other unclassified mycobacteria, by their marked resistance to antimicrobial agents. Marks in England[6] and Engbaek in Denmark[7] have recently reported a series of investigations of an organism called M. xenopei, producing pulmonary and extrapulmonary disease in man. This organism, which is pigmented, shows an unusual pattern of animal virulence, as is seen in Table 1. Virulence for chicks as well as mammals is unique among the mycobacteria.

M. marinum (balnei) infections are well known in the Pacific area. The organism is related to M. ulcerans, since both grow only at reduced temperatures (30-32° C.) and both produce ulcerative or verrucous granulomatous skin disease following direct inoculation.[8]

This array of organisms, sharing some characters, dissimilar in others, are the presently known causative agents of diseases which Runyon has called the mycobacterioses. While the name is only generally descriptive and not clinically useful, the concept broadens a more classic view. It has become apparent that clinical tuberculosis has a wider etiologic and, therefore, epidemiologic and therapeutic, base than is sufficiently recognized. From one to ten per cent of all cases, dependent upon geographic location, may be due to acid-fast bacilli which are not M. tuberculosis. Moreover, these infections are attended by a greater mortality than is classical tuberculosis. It is also apparent that there exists a variety of acid-fast bacilli, of reduced virulence for man and laboratory animals, which may be present in any case of pulmonary or extrapulmonary disease. These may be recognized by the perceptive bacteriologist, or by the clinician puzzled over a case which is resistant to reasonable therapy or is an unfamiliar manifestation of tuberculous disease.

Early recognition is vital because of the generally poor results of antibiotic and drug therapy and because of the excellent results achieved by prompt surgical treatment. Diagnostic bacteriology in tuberculosis has been extensively revised as the result of this broadened view of the tuberculous diseases. The suitability of the term "mycobacterioses" may be only an academic matter; the concept of a spectrum of mycobacteria capable of producing human disease, however, is entirely valid and now well substantiated.

The absolute necessity of culture and a searching evaluation of the bacteriologist's reports are the essential aspects of diagnosis in the mycobacterioses. Difficulties in treatment may be expected if both clinician and bacteriologist are not aware of the pathogenic potential of this ever-widening group of acid-fast bacilli. ■

REFERENCES


1. Runyon, E. H.: Recent developments in mycobacteriosis. In Chapman, J. S. (Ed.) The Anonymous Mycobacteria in Human Disease, Thomas, Springfield, 1960, p. 104.
2. Wolinsky, E.: Experience with atypical mycobacterial infections in man, *Ibid.*, pp. 51-53.
3. Will, D. W., Faber, D., Engbaek, H. C., and Jespersen, A.: The pathology of joint disease in rabbits produced by atypical mycobacteria and M. avium. 2, Pathology of disease in joints and tendon sheaths. Acta tubercul. Scand. 44:209, 1964.
4. Meissner, G.: Atypische Mycobakterien: III. Mitteilung. Aviäre und avium-ähnliche Stämme, Zbl. Bakt. [Orig] 180:510 (Dec.) 1960.
5. Scammon, L., Pickett, M. J., Froman, S., and Will, D. W.: Nonchromogenic acid-fast bacilli isolated from tuberculous swine, Amer. Rev. Resp. Dis. 87:97 (Jan.) 1963.
6. Marks, J., and Schwabacher, H.: Infection due to Mycobacterium xenopei, Brit. Med. J. 1:32, 1965.
7. Engbaek, H. C., Vergmann, B., Baess, I., and Will, D. W.: M. xenopei. A bacteriological study of M. xenopei, Acta path. microbiol. Scand., 1966 (in press).
8. Walker, H. H., Shinn, M. F., Higaki, M., and Ogata, J.: Some characteristics of "swimming pool" disease in Hawaii, HAWAII MED. J. 21:403 (May-June) 1962.

*The classification and management of infant diarrheas according to cause is a feasible and rewarding procedure.*

# Early Differential Diagnosis and Specific Treatment in the Acute Diarrheas of Infancy and Childhood

F. D. NANCE, M.D., *Honolulu*

• *"Infant diarrhea" is not a disease entity, but a symptom produced by a variety of causes. It is possible, by a combination of history, physical examination, and rapid examination of a properly collected stool specimen, to classify diarrheas according to the type of immediate, specific treatment indicated. Early specific treatment will in most cases markedly shorten the course of diarrheal diseases. As a result, the need for hospitalization and intravenous fluid therapy will be greatly reduced. Late complications of diarrheal diseases also vary in their etiology, and successful treatment depends on a differential diagnosis.*

IN THE past 50 years, tremendous progress has been made in saving infants and children from the chemical consequences of diarrheal diseases. These chemical changes vary with the severity rather than the cause of the diarrhea. Electrolyte, fluid, and pH disturbances represent the most pressing problem presented by the average diarrhea patient admitted to our pediatric centers.

Experience has shown that most of these patients will eventually recover if they are kept chemically well. As a result, there is a widespread tendency to think of "infant diarrhea," from a treatment point of view, as a disease entity and to ignore the well-known fact that it is a manifestation of many different diseases. This tendency is reflected in numerous papers in our pediatric journals, describing the effect of this or that chemotherapeutic agent, antibiotic, diet, or stool-thickener in "diarrheal disease," without reference to the type of diarrhea being treated. It is also shown in the stereotyped diarrhea routines to be found in the intern's manuals of many of our leading hospitals.

And yet, the child with an indwelling catheter in his veins, with his losses being meticulously replaced milliequivalent by milliequivalent, is by no means always a triumph of modern medicine. There is a strong probability that he would never have had to be hospitalized if someone had given him proper early treatment.

Proper early treatment must be specific treatment, directed at the cause of the disease. To choose the specific treatment, it is necessary to make a differential diagnosis. It is the purpose of this paper to describe a rapid method by which the great majority of acute diarrheas can be classified according to the type of immediate, specific treatment indicated. These specific treatments in no way replace or conflict with intravenous fluid therapy when this becomes necessary; the two are complementary. The sooner diarrhea is controlled by treatment of its cause, the easier is the task of maintaining fluid and electrolyte balance.

## HISTORY

Since most of the statements in this paper represent the result of my own independent observations, it is necessary for me to present my qualifications, so that the reader can fairly judge the credibility of these statements.

My interest in this subject began when I entered private practice in China in 1934. I soon found that one of the major problems facing a pediatrician in China was bacillary dysentery: severe, killing dysentery, caused by strains much more virulent than those usually encountered in the United States. Frank Haughwout,[1] a parasitologist of long experience in the Far East, demonstrated to me

Received for publication October 28, 1966.

that it was possible, by direct microscopic examination of fresh stools, to make an immediate diagnosis of Shigella dysentery. He also told me that despite the statement by the Council on Therapy of the AMA that "antidysentery serum has proven worthless in the treatment of bacillary dysentery," that it was extremely effective if given in the first 24 hours of the disease. I put his theory to the test; 25 successive cases of bacillary dysentery in infants and children were treated with serum given in the first 24 hours of their disease. All cases were clinically well within 24 hours of receiving serum, and I was convinced.

However, serum was a two-edged sword; at least 25 per cent of the patients got serum sickness. Obviously, such a weapon had to be used with caution, *only* on cases of shigellosis. It was only useful when given early; some mitigating effect on the disease was noted in patients given serum between 24 and 48 hours after onset. In patients given serum more than 48 hours after onset, the only effect noted was to complicate their dysentery with serum sickness.

Thus, diarrhea became for me an emergency situation, requiring that the child be seen and a stool be examined as soon as possible, day or night. After seven years of personally examining the stools of every diarrhea patient I treated, and correlating these findings with the history, physical examination, results of cultures, and the ultimate course of the disease, a diagnostic pattern for diarrheas other than bacillary dysentery began to emerge. Since that time I have personally examined the stools of every case of diarrhea I have treated; in thirty years, well over 5,000 cases. It is from this experience that the following conclusions have been drawn.

## TREATMENT CLASSIFICATION OF ACUTE DIARRHEAS

Differential diagnosis is based on three factors: (1) History, (2) Stool findings, (3) Physical examination. This last is the least informative, and I would advise those busy practitioners who feel they have no time to spend doing stool examinations that they cut their physical examinations short by five minutes and spend that time over a microscope. The method of stool collection and examination is described in Appendix A. The diagnostic findings and specific treatment in the various "treatment classifications" are summarized in Appendix B. If one constantly keeps in mind the pathology of the disease involved, it will soon become unnecessary to refer to these tables. The diagnostic findings are the result of the pathology.

### *Group I—Shigella Dysenteries*

*Pathology:* Shigella dysentery is an acute, fulminating, ulcerative colitis, associated in some strains with an acute toxicosis.

*History:* Onset is usually abrupt; there is almost always significant fever. Cramps are usually a prominent feature. With some strains convulsions or meningismus may be seen even before the onset of diarrhea. Since the inflammatory process is low in the G.I. tract, vomiting is seldom a major feature. Shigella dysenteries are commonest in the hot months of the year.

*Physical Findings:* Abdominal tenderness is commoner in shigella dysentery than in other types of diarrhea.

*Stool Findings:* The essential feature is massive amounts of pus in the stained mucus. There are almost always phagocytic monocytes as well. These may be easily confused with amebae in unstained stools, as they often contain ingested red cells and pus cells. On stained smears differentiation is easy; the characteristic cartwheel nucleus of an ameba bears little resemblance to that of a phagocyte, which is usually fragmented, consisting of scattered pieces of pyknotic nuclear material. All cells, including epithelials, show toxic degeneration. RBC vary from microscopic to gross blood, depending on the depth of the ulcerations. The odor of the stool is seldom offensive, often being semenlike. Consistency of stool varies from constipated to watery; all will show the same microscopic features.

To reiterate, it is necessary constantly to think in terms of the pathology of the disease. In this light, one is forced to reject the following statement taken from the 1964 edition of the Academy's authoritative Red Book[2]: "only half or less of patients have characteristic stools streaked with blood or pus," and rewrite the sentence to read "as stools are collected* and examined by the average laboratory, less than half of those which show a positive culture for Shigella will be reported as showing blood or pus." It is manifestly impossible that fecal material passing across acutely inflamed, raw, oozing, ulcerated surfaces should not carry with it evidence of that intense inflammatory process. If a child with diarrhea shows a positive stool culture for Shigella, and properly obtained, properly examined stool does not show pus, then that child is a Shigella carrier and his diarrhea is due to some other cause.

*Specific Treatment:* The essential of treatment is medication to eradicate the causative organisms. Serum has fortunately been replaced by less toxic agents.† The use of insoluble sulfonamides is illogical; the organisms producing the symptoms are not those residing in the lumen of the gut. If, as will be explained below, the differential diagnosis

† Recent experience has shown that Ampicillin is now the drug of choice.

from Salmonella dysentery is not clear-cut, Chloromycetin should be given as well. Antibacterial treatment should be continued until fever has gone and microscopic examination of the stool shows the process to be healed. Diet is unimportant; it should be bland to avoid mechanical irritation of an already inflamed gut.

#### *Group II—Salmonella Dysenteries*

*Pathology:* Salmonella dysentery is an acute, purulent, sometimes ulcerative enteritis. In young infants it is often an acute, ulcerative enterocolitis. Bacteremia is not uncommon.

*History:* Onset is abrupt; high fever is common, vomiting is usual and often severe. An entire family may be simultaneously affected if the source is contaminated food. Like shigellosis, it is most likely to occur in the hot months of the year.

*Physical Findings:* Nondiagnostic.

*Stool Findings:* The odor is usually noticeably foul, reminiscent of dead fish. Consistency varies from soft to watery, mucus is present, though it may require careful fishing with fine forceps to extract it from a watery stool. The stained mucus shows pus, in amounts varying inversely with the age of the patient. In young infants the amount of pus may be as massive as that seen in Shigella infections, making a certain differential diagnosis impossible. In all cases there will be at least 2+ pus (see key, Appendix B); macrophages are occasionally present; they are not specific for Shigella infections in infants.

*Specific Treatment:* Once again the essential part of treatment is antibacterial. Chloromycetin and Ampicillin are the drugs of choice, an intramuscular drug being used initially if vomiting is severe. Vomiting can usually be controlled in early cases with an adequate dose of sodium phenobarbital given I.M. (e.g., 1 grain for a 20-pound child), plus Bonamine by mouth in those old enough to take the chewable tablets.

Tetracyclines have been ineffective against most of the strains encountered in Hawaii. I have seen at least five children develop a Salmonella diarrhea while they were under treatment with tetracyclines for a respiratory infection. Diet should be clear liquids until vomiting is controlled; after that time it is unimportant.

#### *Group III—Nondysenteric Enteritis*

*Pathology:* This is a large, hodgepodge group caused by a number of organisms, including E. coli. They have in common a mild, nonulcerative, inflammatory enteritis. Very often no recognized bacterial pathogen will be isolated on culture. Some of these cases may well represent a true viral enteritis, in contrast to the type of viral diarrheas to be described under Group IV.

*History:* Onset is usually sudden; fever is only occasionally seen at onset and is seldom high. Vomiting may be present.

*Physical Findings:* Nondiagnostic.

*Stool Findings:* Consistency is soft to liquid. Color is almost always greenish. The essential finding is pus, in amounts considerably smaller than that seen in the dysenteries.

*Specific Treatment:* This group of diarrheas is self-limited, except when they occur in young infants. In this age group it is safest to assume the infection to be due to E. coli until culture has proven otherwise and to give neomycin or Colimycin by mouth. Otherwise treatment is symptomatic. It is well to remember that neomycin may produce a malabsorption syndrome similar to sprue.

#### *Group IV—Viral Diarrheas*

No viral culture studies can be presented to prove that this group is actually produced by viral infections. The history, course, and response to treatment, as well as the adverse effect of antibiotics, strongly suggest a viral origin. If purists prefer to call this "Group X" I shall be perfectly agreeable. The important thing is that diarrheas fitting these diagnostic criteria respond to the specific treatment outlined below.

*Pathology:* Viral diarrheas are acute, systemic infections, associated with an acute malabsorption syndrome. Even in infants dying of the disease, the intestinal tract shows no inflammatory reaction. The term "virus enteritis" is therefore a misnomer.

*History:* Gives a strong lead to the diagnosis. These diarrheas occur largely in the winter and spring months, and usually in epidemics. They tend to run through the members of a family, one by one, regardless of the degree of sanitation in the household. Onset is usually abrupt, but it may be slow and insidious. Stools are usually explosive, accompanied by large amounts of gas. Fever is seldom prominent. (I used to say never prominent, until an epidemic in 1962 proved me wrong.)

*Physical Findings:* Abdominal distention with marked tympany is the rule. White blood counts, often thought of as a reliable index of viral versus bacterial infections, are worse than useless. Counts may vary from profound leukopenia to marked leukocytosis.

*Stool Findings:* The gross appearance of a fresh stool is highly suggestive of the diagnosis. The color is pale tan, reminiscent of biliary obstruction. When stools are watery, they are foamy. Odor is usually sour. Mothers or nurses will often

report the color of the stools as green. This occurs only after oxidation on a diaper.

Microscopically, the stools show no pus cells. If the diarrhea is violent, epithelial cells may be seen. A curious phenomenon is seen in the stained mucus when mucus is present; aggregations of finely granular eosinophilic material about the size of a red blood cell, but lacking any cell wall or cell structure. The granules are much smaller than those of broken-down eosinophils. For want of a better name, I call them "red blobs." They are not specific for virus diarrhea, being occasionally seen in cases otherwise fitting Group III; however, they are highly suggestive.

The most nearly specific stool finding in viral diarrhea is the presence of a marked excess of fatty acids, as determined by the method described in Appendix A. Considerable excess fatty acids will be seen in infants receiving skimmed milk. The amount of neutral fat present is nondiagnostic. Unless they are on fat-free diets, all severe diarrheas will show an excess of neutral fat, due to rapid transit through the intestinal tract, with insufficient time for digestion.

*Specific Treatment:* Virus diarrheas vary markedly in severity from epidemic to epidemic. In infants under six months of age the disease is always potentially severe, often dangerously so. Over the age of one year it is usually self-limited, except during severe epidemics. What follows below, then, applies in most years only to young infants.

Starvation, for an initial period of at least 24 hours, is the most important single factor in treatment. For patients treated at home this is most easily accomplished by limiting the diet to a mixture of three tablespoons of sugar, one-fourth teaspoon of salt, and one quart of water. Infants take this mixture well and usually do not vomit it; children usually prefer it to be flavored with lemon juice. If vomiting is present, it can usually be controlled with phenobarbital and Bonamine.

When feeding is resumed, it should be with utmost caution, starting with weak skim milk—cane sugar mixtures, gradually strengthened over a period of two to three days. Starch should be kept out of the diet until there is no diarrhea and no abdominal distention for at least two days. Failure to give an initial period of starvation nearly always prolongs the disease considerably. Rapid resumption of starch or fat in the diet usually leads to relapse.

Crude liver extract, in large doses, has a dramatic effect in shortening the course of viral diarrheas. A single dose of 4 cc combined with Xylocaine or Novocaine to reduce pain is usually sufficient. When this is used in conjunction with the diet outlined above, most cases will have no further diarrhea after 24 hours. The use of liver extract in viral diarrheas was started experimentally in 1943, after successfully treating two stubborn cases of celiac disease according to the method described by May, *et al.*[4] The chemical findings in the stools of these patients were like those of celiac disease, and the adverse effect of dietary starch in the two conditions seemed to indicate a similar type of malabsorption. I have been unable to determine what is the factor in crude liver extract which helps these patients. In my hands, refined liver extract and folic acid have been ineffective. Folbesyn, a liver-derived injectable B complex, also works, though not as well as crude liver extract in severe cases.

The importance of diet in the treatment of viral diarrheas once more points up the vital necessity of regarding diarrhea as a symptom produced by a variety of causes, rather than a single entity called "infant diarrhea," or "the diarrheal state." One of our most eminent authorities writing on the place of diet in the treatment of diarrheas, has stated,[3] "Relapse in diarrheal states is due to the vagaries of the disease being unrelated to the food load. This was demonstrated in 1947 in Bratislava where the treatment of the disease was varied in alternating cases by full feeding and conventional starvation." I have little doubt that most of these cases were dysentery. If this same crucial experiment had been carried out in the winter in Hawaii during one of our epidemics of virus diarrhea the conclusion reached would have been exactly opposite.

#### *Group V—Food Poisoning (Staphylococcal)*

*Pathology:* The disease is produced by the central and gastrointestinal effects of staphylococcal toxin.

*History:* Onset is usually catastrophic with violent vomiting and diarrhea. It usually affects a group of people simultaneously, shortly after the ingestion of a common meal. This same picture can be produced by the ingestion of a number of chemical poisons; careful history-taking is essential.

*Physical Findings:* Shock and hypothermia are common.

*Stool Findings:* The stools are lienteric: i.e., due to rapid transit through the intestinal tract, they closely resemble gastric contents unchanged by digestion. Epithelial cells may be present in large numbers, but not pus.

*Treatment:* Intravenous fluids for shock and dehydration. Since this is not a staphylococcal infection, antibiotic therapy is pointless.

#### *Group VI—Allergic Diarrheas*

*Pathology:* Since these children do not come to

autopsy, it has to be deduced from the stool findings: an acute allergic reaction with local cosinophilia involving the mucosa of the gut. In very young infants, small ulcerations with local inflammatory reaction are added to the picture.

*History:* Onset may be slow or abrupt, depending in the degree of sensitivity. Infants will usually have an antecedent history of colic. Vomiting is common.

*Physical Findings:* The occasional presence of antecedent eczema is helpful; the simultaneous appearance of hives is almost diagnostic.

*Stool Findings:* Color, consistency, and odor are nondiagnostic. Mucus is invariably present if the specimen has been properly collected. (See Appendix A, Paragraph I.)

The microscopic picture varies sharply with the age of the patient. In older infants and in children, the cell exudate consists of epithelial cells, often in large numbers, eosinophiles in substantial numbers, occasionally a rare pus cell. Blood is present only if diarrhea is violent.

In infants under the age of six weeks gross blood is almost invariably present. Substantial numbers of pus cells are frequently seen, often outnumbering the eosinophiles. Since five to ten per cent of the leukocytes seen in Salmonella and Shigella infections are cosinophiles, the microscopic picture in this age group is not unlike that of salmonellosis in an older child.

*Specific Treatment:* Removal from the diet of the offending food, as determined by history.

For years I was disturbed by the presence of pus in very young infants and often gave way to the temptation to give sulfonamides or antibiotics. Finally, realizing that a very young infant with a Salmonella infection is a very sick baby, whereas these infants most obviously were not, and had no fever, I omitted antibacterial therapy. Pus cells, along with the eosinophiles regularly disappeared from the stools within 48 hours of a change in diet.

I interpret this finding as follows. The age period in which this phenomenon is seen roughly parallels the time during which bottle fed infants develop antibodies to the E. coli which constitute the main flora of their intestinal tracts. Minute ulcerations of the intestine are indicated by the almost invariable presence of gross blood in their stools.

I feel that the pus seen in these stools reflects an inflammatory reaction within these ulcerated areas to the normal E. coli populating the intestinal tract before antibodies to E. coli have been substantially developed. Confirming this interpretation is the fact that I have never seen such a cell picture in breast-fed infants suffering from allergic diarrhea. In these individuals the major intestinal flora are lactic acid bacilli.

### DIAGNOSTIC APHORISMS

(1) The dysenteries tend to occur in the hot months; viral diarrheas are largely seen during the cold months, usually in epidemics affecting one by one the adults as well as the children of a family.

(2) When a whole family or group of people who have eaten together come down with diarrhea at the same time, the diagnosis rests between Salmonella infection and food poisoning, usually due to Staphylococcus toxin. If there is pus in the stools, the diagnosis is almost certainly salmonellosis.

(3) Significant degrees of fever at the onset of a diarrhea favor a diagnosis of Shigella or Salmonella infection.

(4) Pus in the stool means bacterial infectious diarrhea. Large amounts of pus mean either Shigellosis or Salmonellosis. The more the pus, the more likely is it to be Shigella; the fouler the odor, the more likely is it to be Salmonella.

(5) Absence of pus in the stools of a diarrhea of clinically infectious origin favors the diagnosis of viral diarrhea; if this stool is pale, greasy, and explosive, the diagnosis is almost certain; demonstration of a large excess of fatty acids in the stool clinches the diagnosis.

(6) If eosinophils outnumber pus cells in a diarrheal stool, the major problem is allergy. In very young bottle-fed infants pus cells may greatly outnumber the eosinophiles. If such a young infant is obviously not sick, his problem is also allergy.

### OTHER ACUTE DIARRHEAS

Nearly all of the acute diarrheas seen in temperate climates will fall into the previously outlined categories. *Asiatic cholera* is not seen in the United States and has therefore not been described. *Amebic dysentery* is quite rare in our pediatric age group. It is well to note, however, that amebic dysentery does not have an abrupt onset with high fever and massive amounts of pus in the stools. If amebae are seen in the stools of such a case, his bacillary dysentery should be treated first, and his amebiasis later. *Ulcerative colitis* may show after several days a cell picture similar to dysentery; in its early stages the cells are largely cosinophiles. *Staphylococcal enterocolitis* also shows a cell picture similar to dysentery. The history of prolonged antecedent antibiotic therapy, plus large numbers of staphylococci in the stained smear, should make the diagnosis clear.

### NONSPECIFIC THERAPY

Kaolin and pectin mixtures and their variants are very popular in the treatment of diarrhea. This may be termed the "ocular" treatment of diarrhea.

By a mechanical thickening action, stools are rendered more pleasing to the eye; a source of considerable comfort to parents. I see no objection to their use, provided they do not replace specific therapy and provided the doctor remains aware of the fact that they may mask fluid losses. A glass of gelatin is solid, but it contains just as much water as a glass of plain water.

## LATE DIARRHEAL COMPLICATIONS

Most diarrhea patients, treated as I have outlined above, respond quickly insofar as their diarrhea is concerned, within three to four days at the outside. A few, however, even though their fever and "toxicity" may have disappeared, continue to have diarrhea. Such cases call for prompt reevaluation. At least five different causes for persistent diarrhea can be recognized by a repeat stool examination; each calls for its own specific treatment.

*Wrong Diagnosis:* This is most apt to occur in Salmonella infections. Unlike the rule in Shigellosis, pus does not invariably appear in the stools in the first 24 hours, and the case may have been classified as viral diarrhea or toxic food poisoning. Treatment: Give the appropriate specific therapy indicated by the new diagnosis.

*Persistence of the Original Cause:* This can be determined in bacterial infections and allergic diarrheas by a persistence of the original cell picture. We have no reliable criterion in the case of viral diarrheas. Treatment: (a) In the case of bacterial infectious diarrheas, change the antibacterial agent, guiding such change wherever possible by cultures and sensitivity determinations. (b) In allergic diarrheas, try another diet.

*Postdiarrheal Celiac Syndrome:* These infants respond with diarrhea whenever the diet is expanded. This situation may occur after any type of infectious diarrhea; particularly in cases under Group III treated with neomycin. In viral diarrheas it possibly represents persistence of infection. Stool will show the gross and chemical findings described under viral diarrheas. Treatment: liver extract I.M., as described under virus diarrheas. If the case was originally one of virus diarrhea, a second period of starvation is indicated.

*"Diarrhea Habit":* In these cases the gut has been rendered so irritable by antecedent infection that diarrhea persists on a purely mechanical basis. Stool will show no pus, no eosinophils, and normal amounts of fatty acids. Treatment: paregoric or Lomotil.

*Activation of Gastrointestinal Allergy:* This is the most interesting of the late diarrheal complications and the most rewarding one to diagnose. The typical history, stool findings, and treatment can be best described by a brief case history.

A number of years ago, while visiting one of our pediatric centers, I was asked to see in consultation a nine-month-old infant, then in the second month of her hospitalization. Her original diagnosis was salmonellosis, amply confirmed by typical onset, fever, and positive stool culture. Fever and toxicosis had rapidly subsided after treatment with Chloromycetin; diarrhea and positive stool cultures had persisted. Every antibiotic and chemotherapeutic agent said to be effective against Salmonella infection had been tried alone and in combination.

The record showed a history of bottle feeding on evaporated milk since birth. She had been colicky for the first four months of life; after that there had been no feeding difficulties. I examined a fresh stool which showed large numbers of eosinophils and no pus cells. All treatment was stopped and cow's milk eliminated from the diet. Within 24 hours this month-long diarrhea stopped. She remained a Salmonella carrier.

## DISCUSSION

This classification of acute diarrheas has gradually evolved over a number of years from observations on private patients seen in my office. For this reason, no large series, with cultures on all cases, can be presented. It is hoped that this paper will stimulate such an investigation in a center with large numbers of patients, and facilities for both bacterial and viral cultures.

It is to be emphasized that this is a clinical classification, based on the pathology as deduced by history and stool findings. Its sole claim to validity rests on the results obtained by its use as a guide to treatment. Thus, the use of the labels "Shigella" and "Salmonella" for Groups I and II should not be construed as a claim that these are infallible diagnostic criteria. The labels are used because these organisms were regularly found when cultures were taken and a pathogen isolated, and because the pathology revealed by stool examination was in agreement with the known pathology produced in the intestinal tract by these organisms.

## RESULTS OF TREATMENT

For the past 15 years, since Chloromycetin has been available, treatment of diarrhea in my practice has followed the outline noted in Appendix B. In viral diarrhea, liver extract by injection has been given to all infants under six months, and to those infants between six months and one year whose disease appeared to be severe. In the great majority of cases, treatment has been started within 24 hours of the onset of diarrhea.

In these 15 years over 4,000 cases have been treated. Mortality was zero. Only six cases required hospitalization: One of staphylococcus food poisoning, two each of Salmonella and Shigella infection with positive cultures, and one of virus diarrhea.

In 1964, a typical year, the cases were distributed as follows:

| | | |
|---|---|---|
| "Shigella" | 21 | 7.8% |
| "Salmonella" | 56 | 21.1% |
| Group III | 36 | 13.5% |
| Virus Diarrhea | 117 | 44.1% |
| Food Poisoning | 5 | 1.9% |
| Allergic Diarrhea | 31 | 11.6% |
| Totals | 266 | 100% |

Two hundred forty-one (241) of these cases were seen, and specific treatment started, within 36 hours of onset. The average duration of diarrhea after institution of specific treatment was 36 hours. None required hospitalization. In only one of these early treated cases did diarrhea persist for more than three days after treatment was started. This was an 11-year-old girl seen six hours after the onset of diarrhea. She was classified as Group III by stool findings, and only symptomatic treatment prescribed. Stool examination was repeated three days later because of persistence of diarrhea. The findings at this time were typical of Salmonella enteritis, and Chloromycetin prescribed. Diarrhea stopped 24 hours after Chloromycetin was started. A culture taken prior to administration of the antibiotic was positive for Salmonella panama.

One case of diarrhea was hospitalized during the year 1964, a six-month-old infant brought to me on the third day of his disease, with diarrhea, convulsions, and meningismus. Stool showed massive amounts of pus. Spinal fluid was normal except for increased pressure. Since he was in the age group in which differential diagnosis between Shigella and Salmonella is not clear cut, he was treated with both Chloromycetin and sulfa. He was clinically well before cultures were reported on the third day of hospitalization as positive for Shigella type Flexner.

In no group is the effectiveness of early specific treatment more evident than in virus diarrhea. This is the group that annually contributes the largest number of cases of diarrhea that require hospitalization and intravenous fluid therapy in Honolulu, particularly during the winter months. In the first three months of 1964, for instance, 92 cases of diarrhea were admitted to the Kauikeolani Children's Hospital; 85 required intravenous fluids. This hospital accounts for about one-third of the pediatric admissions in Honolulu. The discharge diagnoses on these cases were:

| | |
|---|---|
| Salmonella enteritis | 3 |
| Pathogenic E. coli | 1 |
| Allergic diarrhea | 2 |
| Virus "gastroenteritis" | 86 |

In contrast are over 1,500 cases of virus diarrhea treated by me in the past 15 years with a regimen of early starvation and parenteral liver extract. Only one required hospitalization.

## SUMMARY

It is well known that "infant diarrhea" is not a disease entity, but a symptom produced by a variety of causes. A method is described by which it is possible to classify most acute diarrheas in their earliest stages, with an accuracy sufficient to guide the choice of immediate treatment directed at the cause of the diarrhea.

Over-all hospitalization rates over a period of 15 years, and more detailed statistics for the year 1964, are presented to demonstrate the fact that early specific treatment will in most cases markedly shorten the course of diarrheal diseases, and reduce the need for hospitalization and intravenous fluid therapy.

The differential diagnosis of late complications of diarrheal diseases is also discussed, and their specific treatment outlined.

## REFERENCES

1. Houghwout, F. G.: Microscopic diagnosis of dysenteries at their onset, JAMA 83:1156 (Oct.) 1924.
2. American Academy of Pediatrics "Report of the Committee on the Control of Infectious Diseases"—1964, Page 107.
3. Ching, A. W., and Holt, L. E., Jr.: The place of oral feeding in infantile diarrhea, Pediatrics 5:422 (Mar.) 1950.
4. May, C. D., McCreary, J. F., and Blackfan, K. D.: Notes concerning the cause and treatment of celiac disease, J. Pediat. 21:289 (Sept.) 1942.

## APPENDIX A

### Stool Exam in Acute Diarrhea—Technical Data

I. *Obtaining Specimens:*

Specimens must be reasonably fresh, and above all, *not dried out*. Diaper specimens are worthless for cell examination. For specimens obtained by parent, diaper should be lined with plastic or waxed paper and material immediately transferred to *wide mouth* screw top jar. Older children may pass specimen directly into jar (mayonnaise or peanut butter jars are usually available) or material poured into the jar from a chamber pot—*never* fished out of a toilet bowl!

In the office, specimens can be obtained from infants by inserting a gloved finger coated with K.Y. jelly into the rectum; in acute diarrhea this will regularly stimulate a bowel movement which can be caught on waxed paper spread beneath the buttocks. In older children,

a glycerine suppository will usually produce a bowel movement in a few minutes. *Don't waste time* on an improperly obtained specimen!

II. *Examination of Cells:*

Likely bits of mucus are picked free from fecal material (or fished out of liquid specimens) with a pair of *smooth tipped* fine forceps. Jewelers forceps are ideal. Mucus is placed on a slide and a cover slip dropped on it, and then examined under low power to determine if cells are present. Several bits should be examined before deciding that no cells are present!!

(a) If cells are present, make a thin film by sliding the cover slip off the slide with the index finger. Immediately heat fix over a flame.

(b) Flood the slide *while still hot* with Wright's stain.

(c) *Immediately* dilute with buffer solution or distilled water.

(d) Allow to stain until a greenish fluorescent scum appears on the surface (usually 5-10 seconds).

(e) Wash off with water, wipe the under side of slide dry and dry over a flame or other source of heat.

(f) Cover with cedar oil and examine under low power and oil immersion.

(g) When cells are deeply bile-stained, as frequently occurs in allergic diarrhea in breast-fed infants, or the pus cells seen in nondysenteric enteritis, cell structure may be fuzzy, and the color of cytoplasmic granules masked by the bile stain. If this occurs, wipe off the oil and flood the slide momentarily with the acetone-alcohol mixture used in gram stains, and quickly wash off with water. The cells will now be clear-cut and easy to identify. I am indebted for this observation to Mrs. Katharyn Browne, Chief Technician of The Medical Group Laboratory.

*Interpretation:* The relative number of pus cells is an important differential point. For this purpose, the most heavily cellular piece of mucus found in the specimen is used, and the amounts described under "Key" in Appendix B refer to the appearance of the unstained mucus before making the thin smear. The amount of pus seen in Group III cases is small, and it sometimes has to be searched for—that is the reason for the expression "*maximum* 5-10 WBC/L.P.F."

III. *Rough Determination of Fats and Fatty Acids:* The efficiency of this method depends on the fact that the eye will ignore two large components of the stool mass—water and bacteria. Gross bits of vegetable material are avoided by selection of the bit of fecal material to be examined. Thus, to the eye, almost everything seen will represent the end product of fat digestion and absorption. The variations we are looking for are *gross,* and must be so to be significant.

*Procedure:*

1. Thoroughly emulsify a bit of fecal material in one drop of water on a slide.
2. Add one or two drops of a stain consisting of equal parts of glacial acetic acid and Sudan III stain and mix thoroughly.
3. Drop on a cover slip and examine under low and high power. Neutral fats will appear as pink-stained globules. Normally this does not exceed 5-10 per H.P.F. *Warning*—mineral oil will fill the field with globules and the method is worthless if mineral oil has been taken!
4. Heat the slide over a flame until it comes to a boil. Re-examine the hot slide. Now, both fatty acids and fats will appear as pink-stained globules and the amount of fatty acids is estimated by the difference in the number /H.P.F. now seen in comparison with the appearance when cold. Normally, this difference does not exceed 5-10 globules /H.P.F. *Soaps* will appear as aggregates of small yellow-to-orange staining globules.

*Interpretation:*

1. Soaps have little significance and vary largely with the proportion of milk in the diet.
2. Marked increase in fats usually indicates rapid transit through the intestine with insufficient time for digestion. In soft or firm stools it may indicate deficiency of fat digestion as in obstructive jaundice or cystic fibrosis.
3. Marked increase in fatty acids indicates *deficient absorption,* and is typical of viral diarrhea, sprue, and celiac disease. In these conditions the slide after heating will seem to contain *nothing* but pink globules, provided the patient is not on a fat-free diet.
4. All this presupposes a normal fat intake, as would be the case in a diarrhea seen early. Allowances must be made if the child has been on a fat-free diet. ■

1133 Punchbowl St.

## APPENDIX B
### Guide for Specific Treatment in Acute Diarrheas

| | DISEASE | SHIGELLA | SALMONELLA | NON-DYS. ENTERITIS | VIRAL | FOOD POISONING | ALLERGIC |
|---|---|---|---|---|---|---|---|
| | History | Onset sudden<br>Usually fever<br>Cramps & tenesmus ++<br>Vomiting rare, seldom severe | Onset sudden<br>Fever usual<br>Vomiting usual, often severe<br>Cramps 0 to ++ | Onset sudden<br>Fever & vomiting not the rule, but sometimes seen<br>Rarely cramps | Onset usually sudden with vomiting, but may be slow & insidious. Stools explosive<br>Winter epidemics | (Staph or chemical)<br>Onset catastrophic<br>Usually occurs in a group of people<br>Vomiting severe | Onset variable<br>Colic & vomiting common |
| | Physical Findings | Fever 0 to +++<br>Abdominal tenderness common | Fever 0 to +++<br>Excess peristalsis | Fever 0 to +<br>No abdominal tenderness | Fever 0 to +<br>Abdominal distention. Tympanites | Fever 0<br>Often hypothermia | Fever 0<br>May have hives or eczema |
| STOOL FINDINGS | color | Variable | Variable | Greenish | Pale tan | Variable | Variable |
| | consistency | Firm to watery | Soft to watery | Soft to watery | Liquid-foamy | Lienteric | Variable |
| | odor | Semen-like | Foul | Variable | Sour | Variable | Variable |
| | plus | KEY—++++ Packed, all fields. +++ Fields full, not packed. ++ 15-20/LPF. + Maximum 5-10/LPF. | | | | | |
| | (a) infants | ++++ | +++ to ++++ | + to ++ | 0 | 0 | 0 to ++ (Depends on Age) |
| | (b) children | ++++ | ++ to +++ | + | 0 | 0 | 0 to rare |
| | macrophages | 0 to ++ | 0 to + | 0 | 0 | 0 | 0 |
| | eosinophils | 0 to + | 0 to + | 0 | 0 | 0 | + to +++ |
| | "red blobs" | 0 | 0 | 0 to + | 0 to +++ | 0 | 0 |
| | fats | Slight to Marked increase | Slight to Marked increase | Slight to Marked increase | Slight to Marked increase | Marked increase | Slight increase |
| | fatty acids | Slight excess | Slight excess | Slight excess | Marked excess | Slight excess | Slight to Marked excess |
| | Specific Treatment | Ampicillin. Soluble sulfonamides in penicillin sensitive individuals | Chloromycetin or Ampicillin. Phenobarbital and Bonamine for vomiting. If differential from Shigella not clear, sulfa as well | Symptomatic except in young infants, where it is best to assume it may be due to E. coli & give neomycin. Watch neomycin cases for celiac syndrome | Crude liver extract 4 cc. I.M. in infants<br>Phenobarbital or Bonamine for vomiting<br>Starvation essential in small infants | Supportive treatment for shock and vomiting | Phenergan for cramps<br>Phenobarbital for vomiting<br>History to identify offending food |
| | Diet | Bland | Clear liquids until vomiting stops<br>Then bland | Bland | Sugar-salt mixture for 24 hrs.<br>Very gradual increases | Nothing by mouth until vomiting stops | Sugar water until vomiting stops |

*Brachial hypertension in an accident victim may indicate an injury to the aorta.*

# Deceleration Injury of the Thoracic Aorta

CARL B. MASON, M.D., and G. CAMPBELL HOBSON, M.D.,* *Honolulu*

• *A circumferential tear of the aorta may occur as a result of rapid deceleration, and may give way later after temporarily closing off. Brachial hypertension and mediastinal widening may suggest its occurrence. Prompt surgery may be lifesaving.*

INJURIES of the thoracic aorta have become a significant problem in the emergency treatment of high-speed-vehicle accident victims. Only ten to twenty per cent of cases of traumatic rupture of the thoracic aorta survive to reach the hospital,[1] and most of these die within the next eighteen hours. Remaining survivors may live for long periods without treatment, only to develop a posttraumatic aneurysm which requires surgical treatment.

The main problem is lack of recognition of significant clinical features and delay in treatment. Because of the severity of the injury, the early clinical picture is often related to the more obvious musculoskeletal or abdominal injuries; the aortic trauma is obscured. Awareness of the possibility of this injury and its repairability will make successful early repair more common.

In the past year, four cases were recognized and treated in two general hospitals, with one survival. The four cases illustrate well the diagnostic features which can lead to the institution of reparative treatment.

## CASE REPORTS

*Case 1:* A 27-year-old Japanese man was admitted to The Queen's Hospital Emergency Room one and a half hours after an automobile accident, unconscious, dyspneic, and cyanotic. The pulse rate was 98 and blood pressure 106/68. No obvious head injury was present, but poor aeration of both lungs with bilateral rales was noted, and rib fractures were obvious. The abdomen was soft, and four quadrant taps were negative for free blood. A portable chest roentgenogram (Fig. 1) revealed bilateral hemothorax, pulmonary congestion, and a widened upper mediastinum. Resuscitation was started with blood transfusions, but the pulse continued to rise and the blood pressure fell to 75/30. As an endotracheal tube was being inserted, cardiac arrest occurred. Resuscitation failed despite closed and open cardiac massage and multiple blood transfusions. Autopsy revealed a massive bilateral hemothorax with a 60 per cent circumferential transection of the thoracic aorta just below the origin of the left subclavian artery.

*Case 2:* A Samoan man, age 25, was brought to the Castle Memorial Hospital Emergency Room three hours after his speeding car collided with a tree, in shock, dyspneic, and complaining of severe abdominal and chest pains. Roentgenograms (Fig. 2A) showed a large left hemothorax with widen-

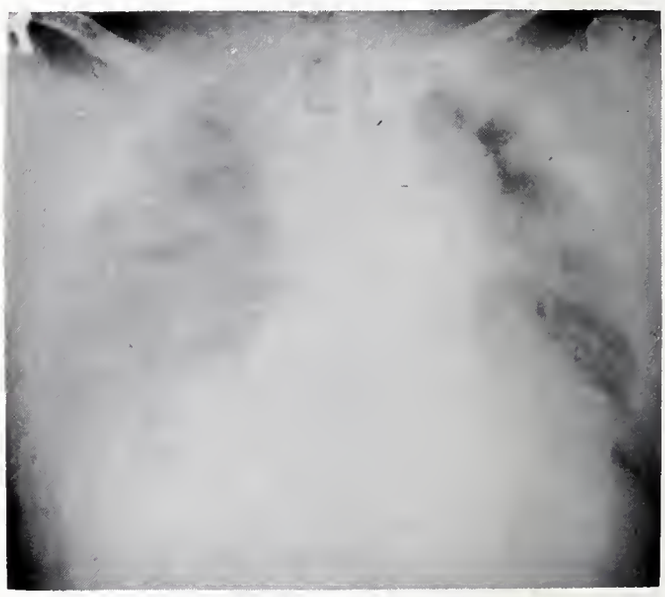


FIG. 1.—*Emergency room chest film shows bilateral pulmonary congestion and a definite widening of the superior mediastinum.*

* Department of Surgery, The Queen's Hospital.
Received for publication October 11, 1966.

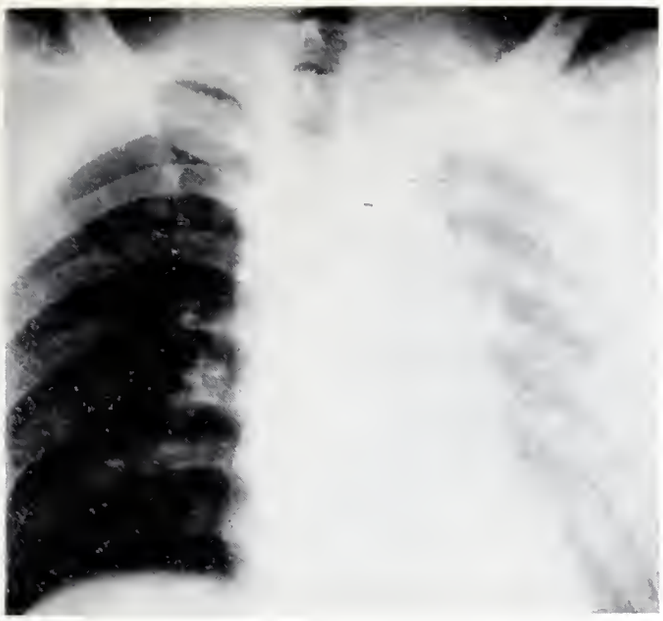


FIG. 2A.—*Initial chest film shows fluid in the left chest, and also a widened superior mediastinum.*

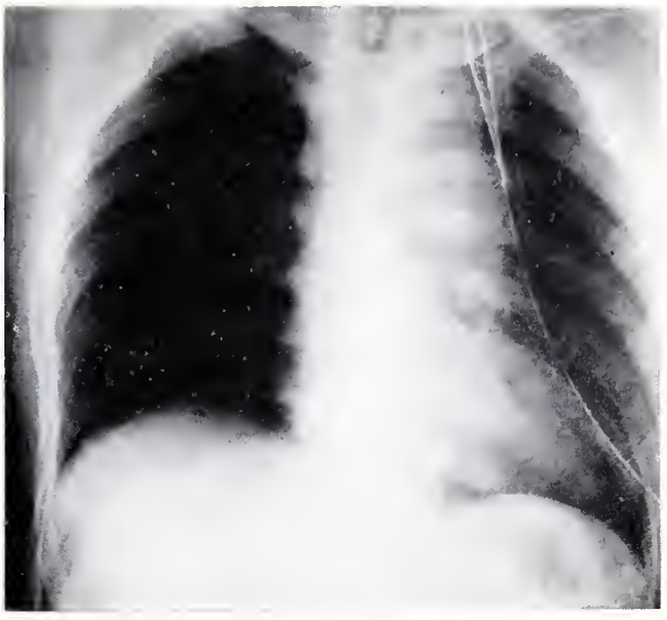


FIG. 2B.—*Persistent widening of the superior mediastinum is seen after removal of the blood from the left chest with a thoracostomy.*

ing of the upper mediastinum. The abdomen was boardlike. During preparation for immediate laparotomy, massive blood transfusions were started and a closed left thoracostomy was performed. This yielded 1,500 ml of pleural blood, and a repeat chest roentgenogram (Fig. 2B) revealed a relatively clean left chest but a persistent widened mediastinum.

The peritoneal cavity contained 400 ml of blood from multiple lacerations of the liver and one of the right renal vein. A low arterial pressure and high venous pressure were corrected by removal of 300 cc of blood by transdiaphragmatic pericardiocentesis. Cardiac arrest occurred as the closure of the abdominal incision was completed, but external cardiac massage and rapid blood transfusions restarted the heart action.

The patient was repositioned for a left anterolateral thoracotomy, which revealed a steady flow of arterial blood from the aorta just distal to the left subclavian artery. With the use of digital pressure, the aortic repair was completed. Cardiac standstill recurred, resuscitative attempts failed, and the patient died eight hours after the injury and five hours after entering the hospital.

*Case 3:* A 22-year-old Caucasian man was admitted to The Queen's Hospital Emergency Room one hour after sustaining multiple injuries in an automobile accident in which he was thrown through the windshield. He complained of chest pain and shortness of breath. Multiple lacerations of the head, neck, and upper extremities were present. Fractured ribs on the right were noted in a roentgenogram of the chest (Fig. 3), which also revealed contusion of the right lung and widening of the upper mediastinum.

Vital signs stabilized, so the lacerations were debrided and repaired, and he was admitted to a ward for observation as a possible aortic injury. At 8:15 A.M., six hours after admission, he complained of severe epigastric pain, became dyspneic, and lost consciousness. Vigorous resuscitative measures, including blood transfusions and open cardiac massage, were instituted immediately. The left thoracotomy released 2,000-3,000 ml of blood, and after cardiac massage failed, postmortem examination of the aorta revealed a two-thirds transection just distal to the left subclavian take-off.

*Case 4:* This 15-year-old Caucasian boy was admitted to The Queen's Hospital one hour after being knocked from his motorcycle by an automobile. He complained of severe pain involving the chest, abdomen, and left leg. Examination revealed a laceration of the left forehead, boardlike

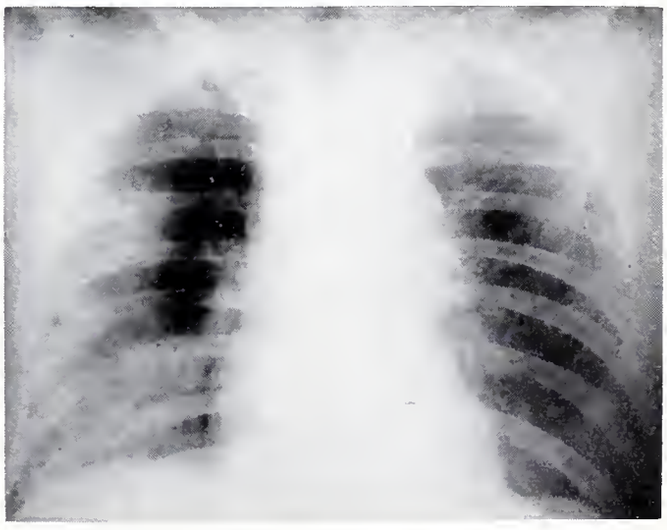


FIG. 3.—*Fractured ribs, contusion of the lung with widening of the superior mediastinum are shown in the initial chest film.*

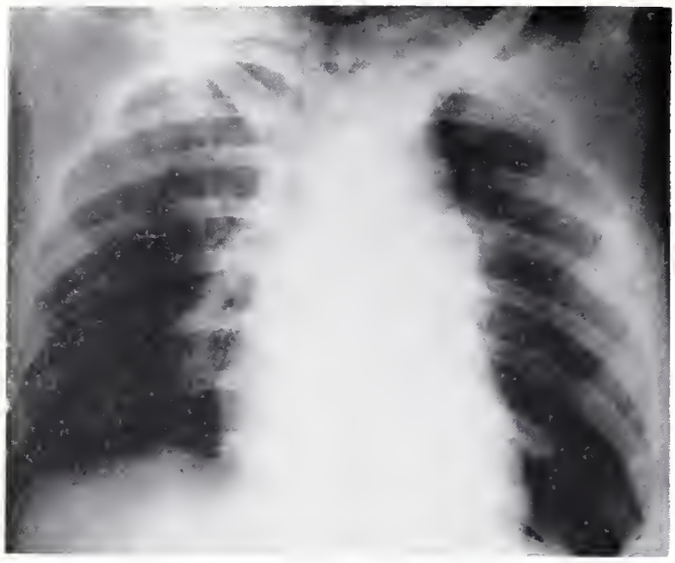


FIG. 4A.—*Admission chest film shows clear pulmonary fields but a widening of the superior mediastinum.*

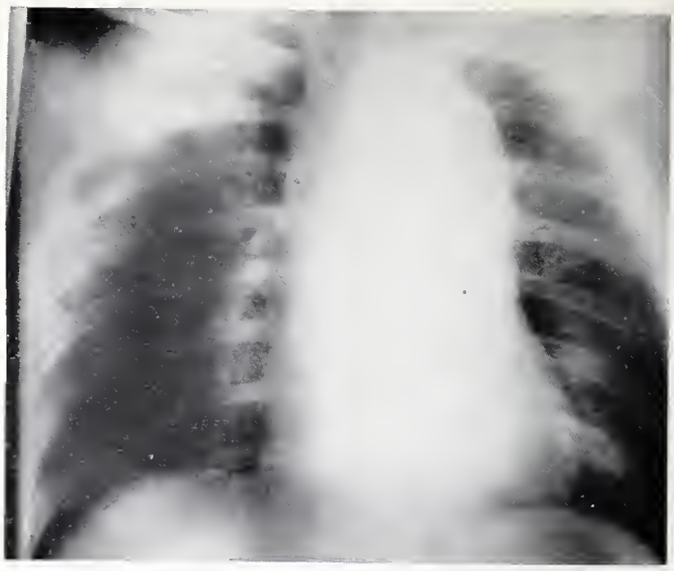


FIG. 4B.—*Follow-up film 24 hours later demonstrates the persistent widened mediastinum.*

rigidity of the abdomen, fractures of the pelvis, left femur, and left tibia and dislocations of the left hip and right ankle. The left popliteal and pedal pulses were absent. A peritoneal tap was positive for blood. A chest roentgenogram (Fig. 4A) showed no rib fracture, but a widening of the mediastinum was evident.

At laparotomy, lacerations of the transverse and sigmoid colon were found and repaired. Hematomas of the duodenum and pelvis were noted. The left femoral fracture was realigned and fixed with an intramedullary nail. An operative arteriogram demonstrated a normal femoral arterial system. The left hip dislocation was reduced. A subsequent chest roentgenogram (Fig. 4B) that day revealed further mediastinal widening, but chest symptoms were less prominent.

On the 33rd day of hospitalization, a persistent brachial hypertension was noted. Roentgenograms of the chest revealed a small but still obvious widening of the mediastinum, and barium-swallow x-ray studies showed esophageal displacement (Fig. 4C) suggesting a traumatic aneurysm of the aorta. Retrograde aortography (Fig. 4D) demonstrated a fusiform dilatation of the thoracic aorta distal to the subclavian artery.

Surgical repair of the 3 x 5 cm aneurysm was accomplished by resection and replacement with a woven Teflon graft, utilizing atrial-femoral bypass. A complete circumferential tear of the intima with separation of the aortic segments was seen grossly. Microscopic studies showed a good healing reaction with separation of the intima and media from the adventitia. The postoperative course was uneventful.

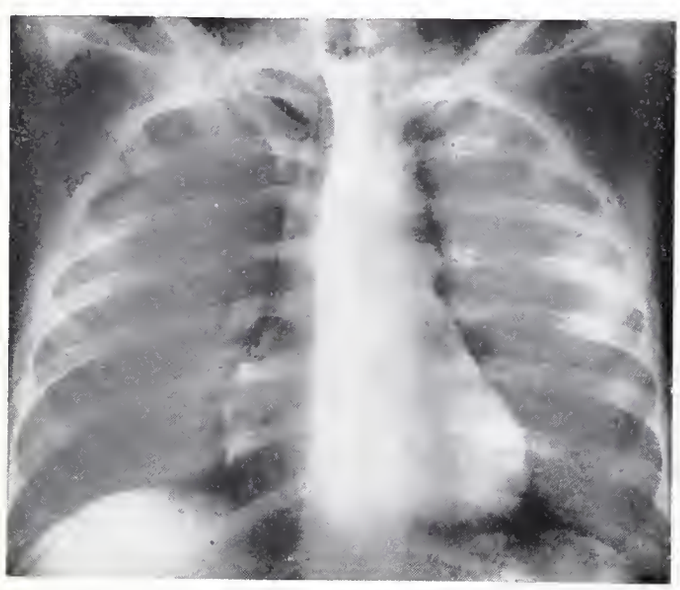


FIG. 4C.—*An esophagogram shows right lateral displacement of the esophagus and an irregular aortic shadow.*

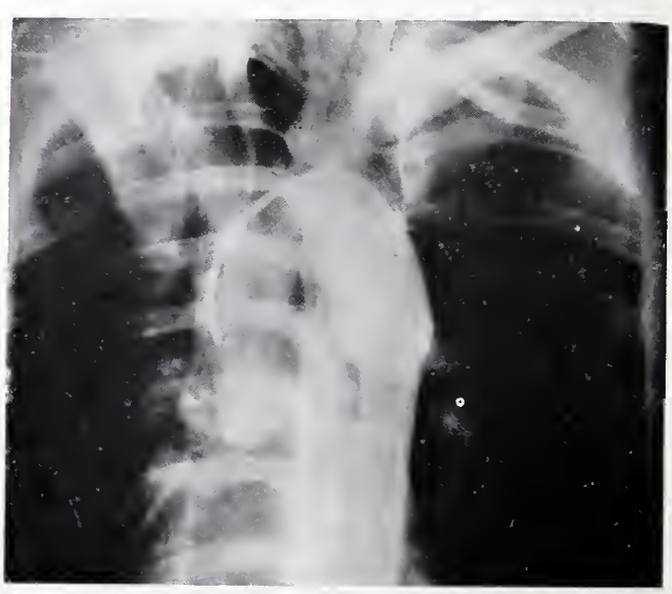


FIG. 4D.—*Retrograde aortography demonstrates the pronounced dilatation distal to the left subclavian artery . . . traumatic thoracic aneurysm.*

## COMMENTS

Case 1 illustrates the usual severity of injuries associated with rupture of the aorta, which allows little time for definitive diagnosis, let alone repair. The remaining three cases well demonstrate the multiplicity of injuries which obscure the aortic rupture. Radiographic widening of the mediastinum was found in all four cases. Cases 2 and 3 were observed long enough to warrant aortography and possible reparative treatment. In the fourth case, the delay was not fatal, and the brachial hypertension,[2] 33 days after injury, led to diagnostic aortography and successful repair.

## ETIOLOGY AND PATHOLOGY

Almost all cases of aortic rupture occur in vehicle accidents involving rapid linear deceleration. The mechanism of injury has been extensively reviewed.[3,4] Uncommon causes include a fall from a height,[5] direct crushing blows to the chest, and a sudden rise in intravascular pressure, as may occur in a cave-in. The aortic injury is usually just distal to the take-off of the left subclavian artery but can occur in the ascending aorta in vertical deceleration.[5] The aortic arch, ascending aorta and abdominal aorta are rarely involved.

The tear in the aorta may involve only the intima with simple local hematoma or may involve all layers of the aortic wall with complete separation of the vessel; it may involve a portion or all of the aortic circumference, and usually begins in the intima and extends outward to the pleura.[3] Survival is dependent on the formation of a hematoma and perhaps on the integrity of the overlying pleura. The original tear may seal off temporarily and then bleed later, following disintegration of the thrombus. Dissection of the aorta is rarely encountered if a normal aorta is injured. Eventually, if the patient survives, an aneurysm is formed which may remain stable, to calcify, mimicking syphilitic or arteriosclerotic lesions. Some aneurysms enlarge progressively even after 15 years.[6]

## CLINICAL PICTURE

The diagnosis of aortic injury is usually difficult because of the severity and variety of other injuries sustained in high-speed accidents. A victim can be either secured in a car seat or thrown free.[7]

Complaints of dyspnea and severe chest pain and back pain are common symptoms, but may be overshadowed by the complaints of other injuries. Hoarseness or dysphagia may indicate the pressure of an enlarging hematoma of the aorta on the left main stem bronchus, recurrent laryngeal nerve, or esophagus. Physical findings may reveal no evidence of chest injury, although fractured ribs and massive hemothorax should make aortal rupture highly suspected. Blood pressure readings are variable; hypotension may precede an unexplainable brachial hypertension. Aortic systolic murmurs are rarely heard. Paraplegia has been reported as the initial finding.[6] After the hematoma organizes and an aneurysm forms, the patient may be asymptomatic. A routine chest roentgenogram may later disclose the lesion.

Chest x-rays show a widened superior mediastinum and often a hemothorax. The former, due to bleeding into the mediastinum from the torn aorta, is diagnostic.[8,9] Tracheal displacement and fractures of the ribs, sternum, or thoracic vertebrae may be present. Emergency aortogram, either retrograde or antegrade, usually will demonstrate the lesion and should be done on all suspected cases.[10,12] The aortogram is certainly less shocking than a thoracotomy in the severely injured patient.

## TREATMENT

Once the diagnosis has been confirmed by aortography, surgical attack is the only alternative to catastrophic temporizing "until the patient is in better shape." Through an adequate thoracotomy incision, careful isolation of the aorta proximal and distal to the hematoma, thereby not entering the hematoma directly, will enable control of the aneurysm. An extracorporeal shunt from the left atrium to the left femoral artery with pump assistance, as recommended by Gerbode,[4] permits adequate circulation to the spinal cord and structures distal to the clamped aorta. If such elaborate equipment is not available, connection of the subclavian artery and distal aorta with plastic tubing has been successfully employed.[13] Aortic occlusion longer than 20 minutes is often associated with ischemic spinal cord damage.[14] Resection of the damaged aortic segment and reestablishment of aortic continuity by either woven Teflon graft or end-to-end anastomosis[15,16] are accomplished. Good results with the described surgical techniques and the possibility of further expansion of the aneurysm, often over a period of years, indicate that excision is the treatment of choice.

## SUMMARY

Four case histories illustrate the need for an increased appreciation of the possibility of aortic injury in high-speed deceleration accidents, and of the possibility of surgical repair. Three of the four cases survived long enough to permit aortography and definitive treatment. One of the three was carried to a successful restorative repair.

The usual lesion, a circumferential tear, just distal to the left subclavian origin, occurs after rapid deceleration. This may seal off temporarily, only to exsanguinate with later disintegration of the thrombus, especially during the first three to four weeks after injury. Expansion of the mature aneurysm occurs months or years later and then demands definitive treatment.

Diagnostic findings related to chest injury, hemothorax, and widening of the mediastinum are common. Confirmatory aortography must be done with recognition of the important time it consumes.

Immediate thoracotomy is indicated once the diagnosis has been confirmed, with repair or excision of the injured segment and reestablishment of aortic continuity. Lack of complex radiographic agencies and pump bypass need not be an insuperable obstacle to successful diagnosis and treatment. ■

REFERENCES


1. Parmely, L. F., Mattingly, T. W., Manion, W. C., and Jahnke, E. J.: Nonpenetrating traumatic injury of the aorta, Circulation 17:1086 (June) 1958.
2. Lafarte, E. F.: Acute hypertension as a diagnostic clue in traumatic rupture of the thoracic aorta, Amer. J. Surg. 110:948 (Dec.) 1965.
3. Cammach, K., Rappert, R. L., Paul, R. J., and Baird, W. C.: Deceleration injuries of the thoracic aorta, Arch. Surg. 79:90 (Sept.) 1959.
4. Gerbode, F., Braimbridge, M., Osborn, J. J., Hood, M., and French, S.: Traumatic thoracic aneurysms: treatment by resection and grafting with the use of extracorporeal by-pass, Surgery 42:975 (Dec.) 1957.
5. Haas, G. M.: Types of internal injuries of personnel involved in aircraft accidents, J. Aviation Med. 15:77 (Apr.) 1944.
6. Spencer, F. C., Guerin, P. F., Blake, H. A., and Bahnson, H. T.: A report of 15 patients with traumatic rupture of the thoracic aorta, J. Thorac. Cardiov. Surg. 41:1 (Jan.) 1961.
7. Greendyke, R. M.: Traumatic rupture of aorta, JAMA 195:119 (Jan. 10) 1966.
8. Steinberg, I., and Evans, J. A.: Roentgen diagnosis of acute and chronic traumatic aneurysm of the thoracic aorta, Amer. J. of Roentgen. 80:237 (Aug.) 1958.
9. Wyman, A. C.: Roentgenologic diagnosis of traumatic rupture of the thoracic aorta, Arch. Surg. 66:656 (May) 1953.
10. Blazek, J. V.: Acute traumatic rupture of the thoracic aorta demonstrated by retrograde aortography, radiology 85:253 (Aug.) 1965.
11. Blake, H. A., Inmon, T. W., and Spencer, F. C.: Emergency use of antegrade aortography in the diagnosis of acute aortic rupture, Ann. Surg. 152:954 (Dec.) 1960.
12. Jahnke, E. J., Fisher, G. W., and Jones, R. C.: Acute traumatic rupture of the thoracic aorta, J. Thorac. Cardiov. Surg. 48:63 (July) 1964.
13. McBurney, R. P., and Vaughan, R. H.: Rupture of the thoracic aorta due to nonpenetrating trauma, Amer. Surg. 153:670 (Apr.) 1961.
14. Adams, H. D., and van Geertruyden, H. H.: Neurologic complications of aortic surgery, Ann. Surg. 144:574 (Oct.) 1956.
15. Alley, R. D., Van Mierop, L. H. S., Li, E. Y., Kausel, H. W., and Stranahan, A.: Traumatic aorta aneurysm: graftless excision and anastomosis, Arch. Surg. 83:300 (Aug.) 1961.
16. Alley, R. D., Van Mierop, L. H. S., Li, E. Y., Jagdish, K. R., Kausel, H. W., and Stranahan, A.: Traumatic aortic aneurysm, Ann. Thor. Surg. 2:514 (July) 1966.

HAWAII MEDICAL ASSOCIATION

# 111th Annual Meeting—1967

Princess Kaiulani Hotel

## PRELIMINARY SCIENTIFIC PROGRAM

### WEDNESDAY, MAY 17

MORNING

7:00 Breakfast

7:15- 7:30 *Greetings* from Theodore T. Tomita, M.D., President of the Hawaii Medical Association

7:30- 8:00 *Genetics in the Practice of Medicine* by Victor A. McKusick, M.D.

8:00- 8:30 Intermission to view exhibits

9:00-10:00 Round Table Discussions

EVENING

7:30- 8:00 *Effects of Dialysis* by Dudley S. J. Seto, M.D.

8:00- 8:30 *Visible Surgical Anomalies in Infancy and Age of Choice for Elective Surgery* by Tague C. Chisholm, M.D.

8:30- 9:00 Intermission to view exhibits

9:00- 9:30 *Introduction of Ovulation* by Georgianna Segar Jones, M.D.

9:30-10:00 *Heritable Disorders of Connective Tissues—Newer Concepts* by Victor A. McKusick, M.D.

### THURSDAY, MAY 18

MORNING

7:00 Breakfast

7:30- 8:30 *Case Presentations from the Birth Defect Center* Presented by Phyllis Wright, M.D. DISCUSSANTS: Howard W. Jones, M.D., Tague C. Chisholm, M.D., Virginia Apgar, M.D.

8:30- 9:00 Intermission to view exhibits

9:00-10:00 Round Table Discussions

EVENING

7:30- 8:00 *Clinical Application of Nuclear Medicine* by Winfred Y. Lee, M.D.

8:00- 8:30 *Fetal Rubella Pathology* by David W. Smith, M.D.

8:30- 9:00 Intermission to view exhibits

9:00- 9:45 Panel on *Therapeutic Abortions for Congenital Anomalies.* PANELISTS: Howard W. Jones, M.D., David W. Smith, M.D., Tague C. Chisholm, M.D., Victor A. McKusick, M.D., Virginia Apgar, M.D., Georgianna Segar Jones, M.D.

9:45-10:15 *Address* by Charles L. Hudson, M.D., President of the American Medical Association

### FRIDAY, MAY 19

MORNING

7:00 Breakfast

7:30- 8:00 *Pronouncement of Sex* by Howard W. Jones, M.D.

8:30- 9:00 Intermission to view exhibits

9:00- 9:20 *Club Feet and Genetics* by James Chung, Ph.D.

9:20- 9:40 *Cytogenetics of Fetal Abortions* by Sorrell H. Waxman, M.D.

9:40-10:00 *Genetics in Mental Retardation* by Ian Shine, M.D.

### SATURDAY, MAY 20

MORNING

7:00 Breakfast

7:30- 8:30 Panel on *Genetic Counseling.* PANELISTS: David W. Smith, M.D., Victor A. McKusick, M.D., Richard Blaisdell, M.D., Stanley Wright, M.D.

8:30- 9:00 Intermission to view exhibits

9:00- 9:45 *Congenital Anomalies—What Price Salvage?* by Tague C. Chisholm, M.D.

Fireside Chats—Tuesday, May 16, Mabel Smyth Bldg.

### Annual Sports and Social Events

Fishing Tournament—Sunday, May 14

Golf Tournament—Waialae Country Club—Friday, May 19

Tennis Tournament—Friday, May 19

Prizes will be awarded on Friday evening, May 19, at the
First Annual Sportsmen's Night
to be held at the Waialae Country Club beginning at 6:00 P.M.

Annual Banquet—Pacific Ballroom, Ilikai Hotel—Saturday, May 20

### House of Delegates Meetings

Wednesday, May 17, 1:00 P.M.

Thursday, May 18, 1:00 P.M.

Mabel Smyth Building




**GRATEFUL ACKNOWLEDGMENT
IS MADE TO THE FOLLOWING ORGANIZATIONS
WHO MADE THE PROGRAM POSSIBLE**

Eaton Laboratories

National Foundation—March of Dimes

E. R. Squibb & Sons

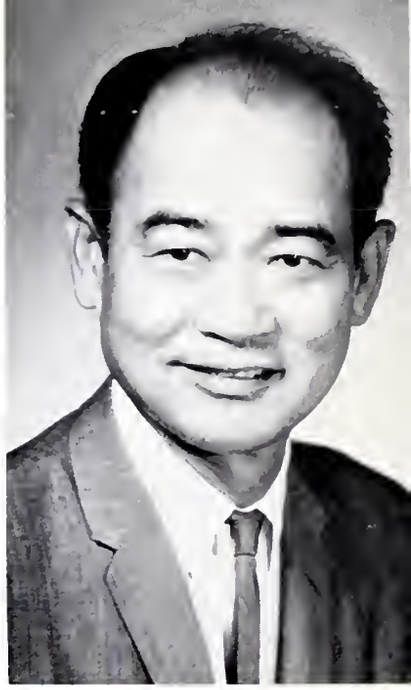
Hoffman-La Roche, Inc.

Schering Corp.

The Wm. S. Merrell Co.

Wallace Laboratories

Strasenburgh Laboratories





# *The President's Page*

Public Law 89-749 provides grants to States for comprehensive health planning agencies in state government. The same legislation also revised the categorical health grants into a single formula grant for comprehensive public health services.

In order to be approved, state plan must provide for the establishment of a State Health Planning Council, with representatives of the state and local agencies, and nongovernmental organizations and groups concerned with health to *advise* the state planning agency. A majority of the Council must consist of representatives of consumers of health services. This concept is also promulgated in PL 89-239, which is the Heart-Cancer-Stroke and related disease program.

Many of our members think such laws were enacted because AMA was remiss and ineffective in Congress or your State or county medical associations have not done their job properly.

The fact is there are some misguided physicians, who under the guise of individualism and individual rights, tend to accept only things that are palatable and acceptable to their individual vested interest, and reject those things which are not agreeable. They have vociferously imposed their will on the majority.

It may be true that the majorities may have been wrong in the past on occasion, but this fact must not blind us to the complementary fact that the majority has usually not been wholly wrong. This minority of physicians has created fragmentation and factionalism within our society. Thus, the voice of organized medicine has become feeble and less effective, and thereby we have become easy victims of exploitation by government and other agencies.

Here in Hawaii we have experienced many episodes whereby the will of the majority has been breached by the emotional bombast of the minority which has created an atmosphere of disunity, and laid us open to be easily overcome by lay organizations and governmental agencies.

We must change our attitudes and sublimate our individual rights, prejudices, and emotionalism. We must settle our petty differences within and create unity, for therein lies our greatest strength.

We can only negotiate from a position of strength if we are to preserve our highest ideals and quality of medicine as a whole.

Theodore Tomita, M.D.

HAWAII MEDICAL JOURNAL

# Editorials

## Privileges

A hospital, under no matter what auspices, is a communal institution. It is like a church, a police station, or a school—belonging to, and a prominent part of, a community.

What goes on within the walls of a hospital is of public concern. Mr. Citizen speaks of "our" hospital, and even though he may not own the smallest part of it, he will—having been a patient in it and having paid his bill—defend his right to have some say about how it should be run.

A doctor who practices in that hospital may have his own office in the town and be a completely private entrepreneur in the community, but when he works within the confines of the community's hospital, he becomes, in fact, a public servant. His image is the composite image of the medical staff, which in turn makes the image of the hospital. What the board of trustees does, or how the administrator meets the public, or how the nurses, the technicians, and the staff function in that hospital, are all accessory to the fact that the professional reputation of that hospital depends upon what its doctors do, as they care for the sick and injured within its walls.

As a comparison, a lawyer who is known to have the privilege of pleading a case in front of the Supreme Court has his stature increased thereby; the court has granted him that privilege in exchange for being assured of the lawyer's good standing. The reputation of the high court enhances the reputation of that lawyer; but the privilege is not bestowed lightly, because the court also stakes its reputation on the good character of the attorneys before its bar. The one depends on the other.

So it is with physicians who treat patients in hospitals.

If a physician is granted privileges by the hospital, he may broadcast the fact to his patients: he has received thereby the community's stamp of approval. Not only is this endorsement made by a public institution, in the public interest, but it further signifies approval by that particular physician's peers.

The responsibility of the grantor is a grave one. The grant cannot easily be retracted, once given, because the retraction would immediately cast a doubt as to the wisdom of the grantor in the first place, and would tarnish the reputation of the institution in the public's eye.

The grantee must understand, therefore, that caution, indecision, and delay are necessary adjuncts to the granting of such privileges. Medical staff bylaws are hedged about with wording to promote exactly these slow and cautious steps towards the ultimate decision. It behooves the applicant to be patient, tactful, careful, extra polite, and superethical. And, if he has succeeded in barely entering the portals: ". . . on probation, under observation," he should choose his cases with infinite care, challenge no accepted standards, defend his own insignificant point of view against no chiefs, and otherwise exercise his very best judgment and skill within the sanctum sanctorum.

Privilege is a grant, not a right. There is no legal or moral right inherent in obtaining endorsement by threat of force.

What a man is, what he has been, what he does, and what he has done in the past are the bases for judgment of him. None of these can he hide for very long. However, what is past is past, and he should be able to count on the natural sympathy of those who look hopefully to the future, to give him a second chance or a fresh start. The applicant is expected to have learned, developed, and improved himself therefrom. It behooves him, therefore, to exhibit penitence and to give promise of being able to do better. The beggar who shows arrogance may end up starving.

For us here on Oahu there is a metropolitan community which, though provincial and island-bound, does consist of a central complex of large hospitals and satellite centers of medical practice in the outlying suburbia. The term satellite may be used in the sense that memberships in the medical staffs of both the central complex and the outlying hospital are generally a part of eaeh physician's armamentarium.

The newcomer applicant for medical staff privileges can apply directly and solely to one of the outlying hospitals of his ehoice, usually situated

within the community where he plans to open his office and live. His application is liable to be considered on the merits of his stated credentials alone, corroborated, of course, by inquiry.

The applicant may, on the other hand, submit his credentials to all the hospitals in the central complex, as well as to the suburban or rural institutions. These credentials may meet with no greater scrutiny, and they may be accepted with equal ease. However, it is in the nature of the system, and quite understandable, that a failure of the application in the central hospital immediately signals a warning to the satellites. There are two major factors involved in this.

One: being in fact satellites, the suburban hospitals naturally look to the central complex for guidance and direction.

Two: the satellite institution must protect its own reputation, not only its local reputation, but also its reputation as a satellite of the central complex. It cannot allow itself to become a back door to the palace.

The physician-applicant cannot but accept the truth of this, the nature of things! If he makes application later, at a hospital that is not even within the purview of his practice or of his living, it is not at all surprising that his motives are suspect. However, he too must eat, earning the wherewithal by practicing his profession. An M.D. after his name and a license number in his pocket, not to mention other certifications, entitle him to a chance. The American Medical Association has stated: "(The AMA) . . . reaffirms its support of the principle that every ethical licensed doctor of medicine who needs or desires them should have staff privileges commensurate with his training and skill, in at least one accredited community hospital."

The hospital of his choice, therefore, should bear the brunt of responsibility of passing judgment on the physician-applicant, giving all the greater weight to consideration of his qualifications, in view of his rejection elsewhere.

The applicant, accordingly, should practice even more the attributes of patience, humility, and tactful conduct, and he should accept the privilege as a privilege, not demand it as a right.

Privilege may not be granted out of pity; the public trust will not permit this charity. If privilege is denied, the decision having been based on an honest appraisal of the available information that can be verified by data at hand, the applicant's recourse to a suit must indeed place on him the very great burden of proving that such denial was actually the result of prejudice. If, because of this threat, privileges are granted against the better judgment of the applicant's peers, then the public interest will be sacrificed and the hospital stands accused of a breach of trust.

The medical newcomer is well advised to clear away all such obstacles to the practice of medicine in hospital, BEFORE he hangs up his shingle!

J. I. FREDERICK REPPUN, M.D.

# . . . a little wine, for thy stomach's sake . . .

Wine is a "safe, long-acting, natural tranquilizer," preferable to drugs that are "artificial tranquilizers," says a distinguished University of California physician in an article in the January issue of the *Illinois Medical Journal.*

Dr. Salvatore P. Lucia, professor of medicine at the University of California School of Medicine, San Francisco, writes that wine "is of far more value as a therapeutic adjuvant in promoting relaxation than is a hastily swallowed capsule."[1]

Wine, he points out, has been used for more than 40 centuries as a safe tranquilizer and there is no reason it should not be used for this even today. Modern research has confirmed the ages-old values of wine, he says. In his view, wine is a "natural tranquilizer" while tranquilizing drugs are "artificial tranquilizers."

Wine, says Dr. Lucia, is more than merely alcohol. "Its many other ingredients bring it into the category of tranquilizers. Many studies of wine disclose that the ability of wine to reduce nervous tension is a result of the ability of its 'chemical symphony'. Numerous studies have shown "that wine gives far more sustained and gently tranquilizing effects than does straight ethyl alcohol diluted with water to the same strength."

One leading possibility for use of wine as a tranquilizer is in the elderly, says Dr. Lucia. It can help them "cope with these tensions and live out a long span in peace and gratitude." One serving before a meal, or two servings with it, provide the desired tranquilization.

"In the rush of rapid pharmaceutical progress, the ages-old established, inexpensive, and safe medicine called wine is apt to be forgotten," writes Dr. Lucia. "So, too, in a post-Prohibition society, these ancient dietary beverages are still apt to be regarded over-emotionally and pseudo-moralistically by the physician. Yet, the long history of the use of wine in medical practice and the modern scientific research confirming its values are gaining the attention of increasing numbers of physicians."

[1] Lucia, S. P.: Wine, tranquility and the physician, Illinois Med. J. 130:70 (Jan.) 1967.

HAWAII MEDICAL JOURNAL

# In Memoriam – Doctors of Hawaii

This is the sixty-sixth installment of In Memoriam—Doctors of Hawaii.

## Carl Frederick Reppun

Carl Frederick Reppun was born March 29, 1883, in Nice, France, the son of Frederick William and Fredericka (Koene) Reppun. His father, of Swedish-German descent, was from the Hansa-Teutonic area of the Baltic Sea. His mother's antecedents were Dutch. The family home was in Riga, Latvia, at that time a Baltic Province of Russia, but they also had a home in Nice on the Riviera.



DR. REPPUN

Dr. Reppun was educated in the schools of Nice, France, and Cassel, Germany, before entering and graduating from the Ludwig-Maximilians-Universität, Medizinische Facultät, Munich, Bavaria, in 1910. He took a further degree in 1912 from the University of Moscow Faculty of Medicine, and did postgraduate work in Vienna.

He married Emily Jane Lewis of Llein, Wales, in 1911, in London, England. They had three sons: Frederick and Eric, born in Russia, and Arthur, born in Hawaii in 1921.

At the outbreak of World War I, Dr. Reppun was practicing medicine as a mining company doctor in the village of Tirljian, in the Ural Mountains between European and Asiatic Russia. He was the only doctor in a radius of 50 miles. Being a Russian subject, he was mobilized into the Czar's army, but remained in Tirljian as the head of the hospital, converted into a military one for the care of the wounded shipped back from the front.

When the Revolution came in 1917, Dr. Reppun was elected President of the local Civil Executive Committee, the Zemstvo or governing body of Tirljian, during the troubled period prior to the Bolshevik regime. As chief of the hospital, he then had occasion to treat both the royalist Cossack wounded and the Bolshevik wounded, depending upon which side happened to be in local control. The house received a direct shell hit once, but the family of four miraculously escaped injury. The Reppuns escaped eastward when the "White Guards" finally retreated before the Communists. In one carriage with one horse, the baggage being in another cart driven by a peasant and his family, they traveled a thousand miles over the Siberian steppes, going along the least frequented byways to Omsk. At the time of starting the journey in the spring, Dr. Reppun himself was just out of bed and convalescing from a nearly fatal typhus infection.

At Omsk, the Reppuns met the advance point of the American Red Cross, which had come there to set up a large hospital under the direction of the late Dr. A. F. Jackson of Honolulu. Colonel Riley H. Allen was the head of the ARC in Siberia. Dr. Reppun was immediately commandeered to assist the Red Cross doctors in their tremendous task. As the Red Cross and the American Expeditionary Forces withdrew toward Vladivostok 3,000 miles away, the Reppun family went along. Mrs. Reppun became a matron in charge of one of the Red Cross nursing homes in Vladivostok.

In 1920, the Reppuns left on the last ship evacuating American personnel to Japan. Two weeks later on July 4, 1920, they sailed on the Army Transport "Buford" for Honolulu, and stayed there. Dr. Reppun first started practice in Honolulu with the late Dr. Bert Mobbs on Beretania Street. In 1923 he went to Kaneohe as Government Physician of the Koolaupoko-Waimanalo District, and as physician for Libby, McNeill & Libby at Kahaluu, before the Libby pineapple cannery was torn down. He also opened an office in the Young Hotel Bldg., and in 1927 gave up the Kaneohe practice completely. The family moved to Manoa, the sons entering Punahou School.

Dr. Reppun was on the medical and surgical staffs at Queen's, St. Francis, Children's, and Kapiolani hospitals. He was on the attending staff at Palama Settlement. He was a member of the A.M.A., the Hawaii Medical Association, the Y.M.C.A., and the Kaneohe Yacht Club.

Following his one and only visit to the mainland, in 1937, Dr. Reppun suffered serious injuries in a car accident from which he never fully recovered. Death came to him on June 7, 1940, at The Queen's Hospital, at the age of 57. ■

Written by Dr. J. I. Frederick Reppun

HAWAII MEDICAL JOURNAL

# This Is What's New!

• **Gastrocamera,** combined with the **fiberscope,** is particularly useful in patients with gastric symptoms but **nondiagnostic x-ray findings.** Twenty cases of early **carcinoma of the stomach** were diagnosed by this combined technique. (*Arch. Surg.* [Mar.] 1967.)

• **Quinacrine (Atabrine)** has been successfully used in the treatment of **malignant serous effusions** by investigators in New York. Of 12 patients treated, two-thirds had objective and subjective improvement of the effusion, although most of the patients had fever and local pain secondary to the treatment. There was no serious systemic or hematological toxicity. Atabrine owes its therapeutic activity in malignant effusions not to its cytotoxic tumor activity, but to its ability to produce an **inflammatory serositis,** fibrosis, and obliteration of portions of the serosal cavity. (*Ann. Int. Med.* [Feb.] 1967.)

• The over-all successes of **EEG** and **brain scan** in **supratentorial tumors** were about the same in 73 patients with verified brain tumors. The over-all figures were 90 per cent by EEG and 86 per cent by brain scan. The brain scan was more successful in localizing meningiomas than was the EEG. When brain scan and EEG were combined as screening procedure, only three per cent of the supratentorial tumors were missed. (*New Eng. J. Med.* [Feb. 9] 1967.)

• **Coxsackie B4** has been isolated from the ventricle of a patient dying of **myocarditis.** A postmortem blood specimen neutralized the virus in a titer of 1:64. (*Aerospace Med.* [Jan.] 1967.)

• **Tumors of the heart** are quite rare but common enough that a group in San Franeisco has recently completed studying and treating a series of ten patients. All of these were operated upon. Nine of the patients had intracavitary tumors; six of the patients made complete recoveries and returned to their normal activities. (*Surgery* [Jan.] 1967.)

• For many years, patients with **gout and hyperuricemia** have noted that they travel in illustrious company, sharing their high uric aeids with such men as Alexander the Great, Benjamin Franklin, etc. Several years ago, a Miehigan study confirmed the belief among hyperuricemics, particularly physicians, that the high uric acid levels were correlated with above average **intelligence levels.** Some hyperuricemics even suggested that their less favored colleagues be given an injection of uric acid from time to time to bring them up to par. Now, six more boys are added to a newly described syndrome consisting of hyperuricemia associated with **mental retardation** and various **neurological and behavioral abnormalities.** Some evidence is presented that reduction of the uric acid by **uricosuric drugs** results in improvement of the syndrome. (*Amer. J. Dis. Child.* [Feb.] 1967.)

• **Penicillamine,** used in the treatment of Wilson's disease increases the amount of soluble collagen in the skin, and appears to be indicated in the treatment of **scleroderma.** (*Lancet* [Nov. 5] 1966.)

• **Polymyalgia rheumatica,** which occurs in middle-aged and elderly persons, is characterized by pain and stiffness about the muscles and periarticular tissues. Weakness, loss of appetite, fever, weight loss, and high sedimentation rate often indicate the systemic nature of the disease. Of 52 patients studied in Sweden and followed for five years, eight have died. Autopsies performed on three of the eight revealed disseminated giant cell arteritis of the aorta, indicating that polymyalgia rheumatica is a systemic form of **giant cell arteritis.** (*Läkartidningen* [Oct. 12] 1966.)

• **Hyperosmolar nonketotic diabetic coma** is described in ten patients in South Africa. The hyperosmolarity is due to hyperglycemia or hyperelectrolytemia or both. Focal or generalized **seizures** may occur as well as coma. Hypoosmotic neutral fluid in large quantities, and insulin, are the recommended treatment. All cases were either newly discovered diabetics or mild diabetics, or both. (*Diabetes* [Oct.] 1966.)

• **Lid retraction** of hyperthyroidism has been successfully treated by **topical** application of **guanethidine.** This agent has previously been used for hyperthyroid crisis. In seven patients treated topically with a 10 per cent solution, the lid retraction and lid lag were reversed or improved. (*Arch. Ophth.* [Sept.] 1966.) ■

FRED I. GILBERT, JR., M.D.

HAWAII MEDICAL JOURNAL

# Book Reviews

## ★ Arteriography Principles and Techniques

*By Joseph L. Curry, M.D., Willard J. Howland, M.D., 328 pp., $14.00, W. B. Saunders Co., 1966.*

THIS IS AN EXCELLENT volume for any physician interested in vascular surgery or roentgenology. Although limited in scope, it is comprehensive enough to give the novice a good grasp of theory and techniques. For the more sophisticated physician, it is an easily read review.

The chapters on cerebral and renal arteriography are particularly good. Illustrations are plentiful and of good quality.

Since the vascular system permeates every organ, it will behoove every physician to know the indications of arteriography, whatever segment of the body he is particularly interested in.

WALTER CHANG, M.D.

## Viruses Inducing Cancer: Implications for Therapy

*Edited by Walter J. Burdette, A.B., Ph.D., M.D., 498 pp., University of Utah Press, 1966.*

THIS BOOK CONTAINS a collection of papers, edited by Walter J. Burdette, by authorities in their fields on the properties, characteristics, and behavior of oncogenic viruses. The information and data are highly technical and of interest primarily to individuals concerned with oncogenic viruses at a very basic level. The contributors in general feel that viruses cause cancer and are more concerned through what mechanisms this comes about. Specifically, the papers review oncogenic viruses in terms of classification, identification, immunity, host response to infection, and the possibilities of preparing vaccines for immunization. The amount of knowledge presented in this book on oncogenic viruses is vast and seems to form a specialized subject in itself.

ROBERT T. S. JIM, M.D.

## ★ The Merck Manual, 11th Ed.

*Edited by Charles E. Lyght, M.D., 1,850 pp., $7.50, Merck Sharp & Dohme Research Laboratories, 1966.*

WHEN THE REVIEWER was a medical student and intern *The Merck Manual* was a bible of medical knowledge and advice. Today this universally popular handbook should still be in the library of every medical student and physician.

As with previous editions dating back to 1899, the objective is to provide physicians with well-organized, up-to-the-minute facts, to reinforce postgraduate medical education, aid in diagnosis, and promote the use of effective therapy.

The eleventh edition is a completely new handbook. Many outstanding clinicians throughout the United States, Canada, and overseas have served as authors and consultants to present the latest developments in all fields of medicine.

Its 366 main chapters and 818 subchapters cover over 1,000 subjects. The diseases are presented concisely with painstaking accuracies, and are well organized.

The manual has grown in size, the print is larger, and the pages are more numerous. I can no longer slip this book into my intern pocket or resident coat. It must join the book shelf.

HAROLD M. JOHNSON, M.D.

★ means highly recommended.

## ★ Psychiatric Drugs: Proceedings of a Research Conference Held in Boston

*Edited by Philip Solomon, M.D., 262 pp., $9.75, Grune & Stratton, 1966.*

THIS BOOK contains the proceedings of a research conference held in Boston to discuss current findings in relation to new psychoactive drugs. Contributors to the conference cover the field of biochemical pharmacology in terms of both newly-proved facts and theories. The most important part of the book concerns itself with a discussion of the combination of drug therapy with psychotherapy and psychoanalysis.

The most important area in which drugs may favorably be utilized as an adjunct to psychotherapy is that of the depressive syndromes. Here the new activating drugs stimulate emotional activity and make the patient accessible to psychotherapeutic intervention. The discussants stress the danger of using these antidepressive drugs without concomitant psychoterapy.

The conference covered material relating to the results of over ten years in the use of various types of tranquilizing drugs in schizophrenia and severely depressed patients in the hospital milieu. Hundreds of papers on controlled studies are now available to prove the antischizophrenic action in all types of this disease and under all conditions of hospitalization. Their role in revolutionizing hospital care of psychotic patients is fully affirmed. Current studies are directed primarily toward attempts to ascertain the reason for their effectiveness.

Controlled studies of the uses of the so-called minor tranquilizing drugs in the treatment of neurotic anxiety and tension lead to the conclusion that they have far less value in this area. Only when anxiety and tension make it impossible for a patient to function in psychotherapy should these drugs be utilized. The danger of undermining normal areas of concern and response must be considered, as judgment can be impaired. The use of the minor tranquilizer as a substitute for psychotherapy was deplored and the point again made that the use of these drugs should never be an end in itself.

Dr. Stanley Yolles, Director of the National Institute of Mental Health, gave an interesting discussion of the Federal Government's role in stimulating and supporting research in the field of psychotropic drugs and in working with the Food and Drug Administration both to speed up approval where this was warranted and exert control over the use of these drugs before safety and effectiveness were proved.

In general, this conference brought up to date the latest findings in the field in all areas. The book is excellent and extremely practical.

FRANCES COTTINGTON, M.D.

## Stereoscopic Atlas of Mastoidotympanoplastic Surgery

*By Harold F. Schuknecht, M.D., Werner D. Chasin, M.D., John M. Kurkjian, M.D., 92 pp., $26.50, The C. V. Mosby Company, 1966.*

THE TECHNIQUES and philosophy of tympanoplasty still vary among otologists throughout the country. This manual illustrates a "conservative" technique which involves complete exenteration of the mastoid air cell system including the posterior bony canal wall and the use

*continued page 361*

## A WASTE OF TIME

It is 9:05 PM as I type this. The military would would have specified "2105 hrs." Other than the clarity that comes from saying "1200 hrs" to mean noon, whereas our system of 12:00 M could be mistaken for midnight, the military system saves no time, except maybe in the key shifting needed to put in the colon.

Why would not 9:05P be adequate? Has anyone ever figured out how much time has been wasted during the past 100 years over the simple matter of adding the "M" to AM and PM?

Today is February 24, 1967. The military has, for over twenty years, saved the time and spaces equivalent to the difference of eight peeks at the typewriter, by recording the date as 24 Feb 67, not counting the time spent in keyboard shifting for punctuation. Just imagine what influence that halving of time and work might have had on our entire civilization, had we taught it universally a hundred years ago!

I must address this missive to the Editor, HAWAII MEDICAL JOURNAL, and mail it off to meet a deadline. The address on the envelope is supposed to include "Honolulu, Hawaii 96813." Why could we not, within our own State, simply save an obvious waste of time by labelling the envelope "Honolulu 96813"? [We always do. It works fine. But why not just "96813"?—ED.]

Our language itself offers barriers to succinct expressions of thought. A rich language is one that has single words to describe nuances of difference in meaning. The Hawaiians say "hano" for the shortness of breath of asthma; "pau paoaho" specifies the S.O.B. of cardiac insufficiency. In English we use the three words (the medical abbreviation may arouse the wrath of a lay person!) that I have abbreviated above, and we do not include the etiology that the Hawaiians have made their one word contain. We are wasting time. Even "dyspnoea" is not so specific.

The uneducated, worried mother of a sick child will tell us over the phone: "Baby has hard breathing," which is a fairly concise expression of fact. However, we must pose a query in return, to determine whether she meant "fast" breathing of fever, as opposed to a true asthma.

The word "dizzy" is a time waster—the medical history-taker has to go on to ask the patient who complains of the symptom whether true vertigo, or just faintness, was meant.

The ultimate in poverty of communication is the phrase "da kine," comparable to the proverbial taciturn "ugh" of the Indian. The Indians had time to waste; we no longer do.

The speed of our times makes it difficult to think leisurely, consider carefully, and conclude wisely. If we are to survive, at least to the extent of saving our nervous systems from going to pieces, we must develop means of saving time.

Have you listened to K-POI lately? Not a second is wasted in program transitioning; the commercial roars in as the music of the last recording fades out; the news is read off by two disc jockeys at top speed, alternately, so that one can take a breath on the other's time. They do it very well—but! Have you ever stopped to think how difficult it is to record in your own senses this drumfire of data? I figure that I must be stupid, and I am wondering if it is a sign of advancing age. Are the youth of today being trained by this sort of sound to be more instantly receptive and retentive than we ever were?

Seriously, there are two major segments of the professional work of us doctors that require a reevaluation, so as not to waste our valuable time. One is the dictum put out by the J.C.A.H.; the other is the book of directives put out by the various levels of government, on MEDICARE, MEDICAID, and the rest.

If the quality of medical care is to be preserved or enhanced, the J.C.A.H. simply must revise its guidelines in the direction of (a) increasing the vocabulary of acceptable abbreviations, and (b) decreasing the need to recapitulate data, already adequately recorded in the body of hospital charts, in a summary. A concerted effort should be made to develop a glossary of clear medical shorthand.

If we are expected to spend more time with our patients—which is the corollary to improvement in quality of medical care, and applies equally to the work of our professional colleagues, the nurses, then the various agencies of the government simply must concentrate on abbreviating the paperwork demanded of us. Legislators seem to be totally unaware of the cost in time, an invaluable commodity these days, associated with the carrying out of the simplest rules, regulations, and laws. ■

J. I. FREDERICK REPPUN, M.D.

HAWAII MEDICAL JOURNAL

# New Members



**Ralph Byron Berry, M.D.**
1250 Punchbowl Street
Honolulu, Hawaii 96813

PUBLIC HEALTH
Creighton Medical College—1937
Internship—San Diego Naval Hospital—1937-1938



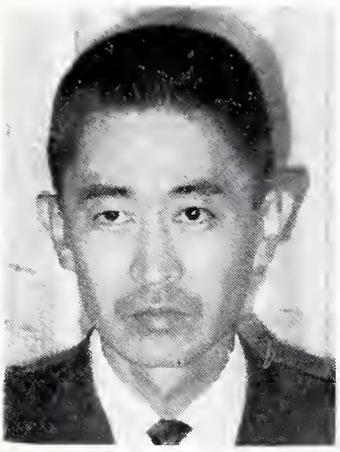
**Alfred Dyer Morris, M.D.**
1133 Punchbowl Street
Honolulu, Hawaii 96813

CARDIOVASCULAR DISEASE
University of Virginia School of Medicine—1955
Internship—U.S. Army, Madigan General Hospital, Tacoma—1955-1956
Residency—Tripler General Hospital—1957-1959
Letterman General Hospital—1960-1960



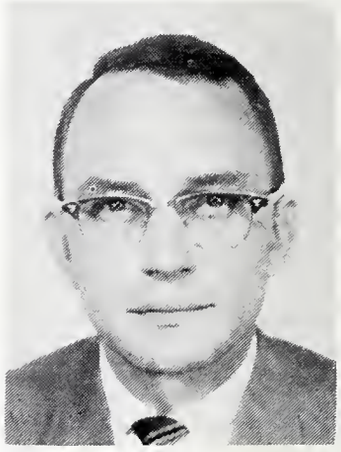
**Dorothy Jane Whittaker, M.D.**
1710 Makiki Street
Honolulu, Hawaii 96822

ANESTHESIOLOGY
University of Cincinnati, College of Medicine—1951
Internship—Jewish Hospital, Cincinnati—1951-1952
Residency—Vanderbilt Hospital, Nashville—1952-1953
Strong Memorial, Rochester, N.Y.—1954-1955
Grace New Haven Hospital (Yale), New Haven—1955-1956



**George Isao Nagao, M.D.**
1133 Punchbowl Street
Honolulu, Hawaii 96813

PEDIATRIC CARDIOLOGY
University of Cincinnati—1959
Internship——Cincinnati General Hospital—1959-1960
Residency—Cincinnati Children's Hospital—1960-1962



**Robert L. Kistner, M.D.**
888 South King Street
Honolulu, Hawaii 96813

SURGERY
St. Louis University—1954
Internship—St. Louis University—1954-1955
Residency—St. Louis University—1955-1960
Cleveland Clinic—1964-1965

HAWAII MEDICAL JOURNAL

# County Society News

## Hawaii

The January 19 meeting was held at the Tropics Lanai. Col. Thomas J. Whelan was the guest speaker. The Treasurer gave his report and advised that dues notices had been sent out. The "Christmas Carousel Group raised approximately $2,800 for the EKG monitor at the Hilo Hospital. A letter was read from Dr. Bergin to Dr. Best outlining the outcome of the HMA/HMSA meeting. No action was taken and a special meeting to discuss this subject was scheduled for January 31. Member physicians were advised of the importance of using the Hawaii RVS. A special committee on fees will be appointed. The status of the maternal health clinic was discussed along with what constitutes "high risk pregnancy." It was noted that after February 1 all DSS prenatal patients would be going to a clinic located in Keaukaha. The licensure requirements for osteopaths were discussed. The meeting concluded with Colonel Whelan's talk on "Surgical Considerations in Occlusive Peripheral Vascular Disease."

* * *

HMA President, Dr. Tomita, was the guest speaker at the February 24 meeting. He covered major areas of concern including workmen's compensation, DSS, the Health Department, and HMSA. A question-and-answer period followed his presentation. At the business meeting it was voted to circulate the minutes prior to each meeting. Dr. Mitchel reported on the Careers Day activities. Dr. Haddon expressed his displeasure at the present plans for a hospital in the Kau district. Dr. Tomita promised to take his views back to the appropriate committee. Dr. Bergin reported on the second meeting with HMSA. Members were invited to make suggestions to Dr. Bergin prior to his attending the next meeting.

It was voted to endorse a diabetes testing and detection program.

## Honolulu

Approximately 155 members attended the January 3 meeting which began at 7:00 P.M. with a film on "Cancer in Children." Two new members were introduced—Allyn J. McDowell and Ronald D. Moore. A program was presented by Mr. Bob Cole, who spoke on "Planning Your Trip." Special lecture by Dr. Jerome Conn on January 27, and a one-day symposium on "Selected Topics in Cardiovascular Disease" on February 5, were announced.

## Kauai

The HMA President, Dr. Tomita, and President-elect, Dr. Richardson, were present at the January 3 meeting. A brief business meeting in which the minutes of the previous meeting were corrected and Dr. Albert C. Johnston was declared eligible for membership. Dr. Tomita covered a number of subjects including negotiations with HMSA; the Foundation Plan; fee schedules for the Departments of Health, Social Services, and Workmen's Compensation; and the problems developing for plantation physicians relative to billings for Medicare patients. Dr. Richardson elaborated on Dr. Tomita's comments, and the meeting adjourned at 10:00 P.M. ■

HAWAII MEDICAL JOURNAL

# Hawaii Medical Association

## MINUTES OF THE COUNCIL MEETING

**February 1, 1967, at 6:00 P.M.**
**Oahu Country Club**

### PRESENT

Drs. Theodore T. Tomita, B. A. Richardson, O. D. Pinkerton, Herbert Y. H. Chinn, R. Varian Sloan, Robert M. Miyamoto, Grover H. Batten, Bernard W. D. Fong, Andrew C. Ivy, Jr., Samuel R. Wallis, William E. Iaconetti (for Joseph E. Andrews), plus Dr. George Mills and Mr. Thomas Rice.

### MINUTES

The minutes of the August 31, 1966, meeting were approved as printed in the JOURNAL.

### COMMUNICATIONS REQUIRING ACTION

*SAMA:* The Student American Medical Association has solicited HMA membership in the amount of $100 annually.

This organization is closely related to the AMA and has done an excellent job in many areas. It was noted that it will not include students of the University of Hawaii Medical School.

**ACTION:**

**It was voted to approve membership in the Student American Medical Association and to submit $100.**

*Department of Social Service Request:* Subsequent to sending out the original agenda a request for a donation of 20 Hawaii Relative Value Studies has been received from the Department of Social Services. The adopted policy of the HMA is that each member, upon request, receives one copy without charge; nonmembers and organizations are charged $5.00; members requesting additional copies are charged $1.50. The cost of printing these schedules (not taking into consideration the cost of conducting the survey) was $1,342.86 for 1,250 copies, or $.54 each. There are some 200 copies still in stock.

**ACTION:***

**It was voted that the Department of Social Services be given two (2) copies of the Hawaii Relative Value Study, and that they be charged**

* This action was subsequently rescinded. The Council voted by mail to set the cost of the RVS at $1.50 each for government agencies which employ HMA members.

*continued page 334*

HAWAII MEDICAL JOURNAL

# Notes and News

## Professional Moves

Chinatown ushered in the Year of the Ram with deafening firecracker volleys and prancing dragon dances: the Oriental sages predict the year to be quiet and harmonious. So be it. . . . In January, dermatologist **Clement Chun-Ming** started his practice at 1350 S. King; **Charles Custer** relocated from turbulent Kahuku to 45-956 Kam Hwy., Kaneohe; internist **Alfred Morris** joined the Medical Group at 1133 Punchbowl: pediatrician **Ann Barbara Ho Yee** opened at the York International Building; and psychiatrist **Leo Anderson** joined the Hawaii State Hospital. In February, plastic surgeon **Victor Hay-Roe** left solo practice and joined the Medical Group while venerable pediatrician **Donald C. Marshall,** retired involuntarily at 65, left group practice and relocated to the Medical Arts Building.

## Hors de Combat

We suffered with the **Ralph Beddows** when their 14-year-old son Mickey was reported missing off Diamond Head and later rejoiced with them when it turned out to be a false alarm. Mickey came ashore at the Natatorium three and one-half hours later where he had been surfing all afternoon. Such are the vicissitudes of parenthood.

We also agonized with Kailua-Kona fisherman **Chisato Hayashi** in his unsuccessful bid to rescue his fishing partner who was swept out to sea while surf-fishing off Keahole Point.

We learned that psychiatrist **James Harrison** has received eight tickets since 1951 and enjoyed his comments: "I'm obviously not careful enough. But except for one case, there was no contact with other vehicles. Mostly it's a result of hurrying. I don't start soon enough. By the way, I'm quite an advocate of traffic safety and believe strongly in the value of seat belts." With such healthy ventilation, he need never fear a fractured superego.

"Someone slipped into Dr. **Sidney Fujita's** offices at 1833 No. King St. yesterday and slipped out again with a cash box containing $190 and cancelled checks." Me thinks it could be a slippery thief.

## Conference Humor

After the traditional three days here, Visiting Professor in Medicine, **Scott N. Swisher,** gave astute commentary on Hawaii; viz., that he had never received such hospitality and courtesy (he even encountered a courteous cab driver!), that he felt that the Honolulu Police Force was so much better disciplined and helpful than anywhere else in the world; that Oriental cooking in its full range made French cooking pale, that the latter is a sloppy mess of sauces; and lastly that the Honolulu "Grand Prix" rush-hour driver can compete with his counterpart anywhere else in the world.

When discussing auto-hemolytic anemia, he listed the anti-gamma factor, the anti-complement factor and other known factors and finally the anti EE factor. When there was a puzzled look on some faces, he explained, after a pregnant pause, that it stood for "Anti Everything Else."

He described the hazards of transfusion reactions as being 80 per cent logistic, i.e., clerical, error. He related how a house officer starting a transfusion was startled when the woman patient looked up at the bottle and commented, "That's funny, I used to be Type O and this bottle says Type A." To make matters worse, her husband at the bedside was a lawyer. "You know what happened," he commented laconically.

Extract from a Queen's Medical Death Conference protocol: "This 66-year-old male was admitted to the hospital because of extreme constipation. . . . Physical examination revealed an emaciated, malnourished male who appeared to be at least 120 years old and chronically ill . . ." (Never having seen a 120-year-old patient, we reserve comment on the intern's ripe imagination.)

The fine art of hedging: Radiologist **Don Ikeda** was asked to comment on a film of a pulsatile abdominal mass in an 88-year-old Chinese man. "I can't really call this an aneurysm, but rather an aneurysmal dilatation." In discussing the mental condition of the same patient, surgeon **Walt Chang** was equally noncommittal. "We can't really call him senile, for he can be aroused when he wants to be."

Surgeon **Vic Mori** finds the vital capacity machine of invaluable use in distinguishing a young 70-year-old from an old 70-year-old.

Derm Conference: A case of Mycobacterium balnei granuloma was described by **Harold Johnson** as being formerly called tuberculosis verrucosa cutis. Internist **Fred Gilbert** was curious. "What happens to the old terminology?" **Harry Arnold** with index finger squibbling in air quipped, "The moving finger writes . . ."

On yet another case, there was friendly debate as to whether the case was that of mycosis fungoides or lymphoma. Pathologist **Drake Will** categorically maintained that it was not M.F., to which the old master **Sam Allison** bantered, "When we dermatologists disagree with the microscopic diagnosis, we resort to what our eyes tell us . . ."

## Elected, Appointed, and Honored

Deserving **Bob Millard** proved that he "knows his money" by recently winning a Rome trip for two in the American Savings and Loan Association's "Know Your Money" contest. We learned that Bob was originally hired to work on Lanai when James Dole purchased the island to grow pineapples. Our own **George Mills** continues to pile up credit points. He was unanimously reelected president of the Hawaiian Civic Clubs at their recent convention at the Kauai Surf Hotel and named "Outstanding Civic Club Member" of the year. **John Chalmers** was elected second vice-president of the Honolulu club and George a director. Irrepressible **Cal Sia** was elected second vice-president of the Child and Family Service and, as chief of staff of Children's Hospital, addressed the 1967 Cancer Crusade workshop where representatives from all the islands were gathered.

It's let's-dig-deep-in-our-pockets time . . . **Ed Helms,** chairman of the Big Island Division of the Hawaii Heart Association, announced that their goal was $17,000. **Raymond J. Wong,** president of the United Cerebral Palsy campaign, topped this by announcing a goal of $25,000. The United Fund elected **Masato Hasegawa** vice-president and **A. S. Hartwell** a director. They haven't announced their goal as yet and we don't dare ask.

With the Tongs: The Wong Kong Har Tong Society elected **Herbert Wong** assistant English secretary; the Pun Tao Club elected **Bernard Fong** vice-president, **Sam Yee** supervisor, and **Wallace Loni** sergeant-at-arms; the Kam Society elected **Joseph Kam** sergeant-at-arms; and the See Yup Benevolent Society installed **Millard Seto** as English secretary.

Miscellaneous: **Richard Sakimoto** and **Tsuneichi Shinkawa** are on the Board of Advisors for the Young Buddhist Association of Honolulu. **Cesar De Jesus** is second vice-president of the Hawaii Council of Camp Fire Girls?? **Wilbur Lummis, Jr.**, was appointed to the $21,500 a year job of Deputy Director of the State Department of Health. **Ralph Berry** was originally appointed, but his appointment was cancelled next day with some embarrassment when it was discovered that Ralph did not meet the State's three-year residency requirement. **David Katsuki**, erstwhile City-County physician, was appointed medical care consultant in the DSS Public Welfare Division. **Warner Bowers**, medical educator, journalist, and former Chief of Surgery at Tripler until 1961, was named Medical Director for the *Medical World News*. Stemwinder **Andy Ivy** was honored as "Society Stem Winder" of the month by AMA's *PR Doctor* in the Jan.-Feb. issue, with a column of richly deserved praise for all his achievements as our PR Committee Chairman for the past four years. Now it's official! Orthopods **Bob Smith, Gabe Ma**, and **Al Kong** all passed their examinations by the American Board of Orthopedic Surgery in January and are now certified specialists. **Harry Arnold, Jr.** was named as one of three AMA representatives on the American Board of Dermatology for a three-year term.

## Sportsmen

*Golfers:* We missed a few late December winners, viz. **Toots Fujii** in A flight at the WCC and Toots and **Roy Tanone** in team best ball. **Allen Leong** also took A flight with a creditable 77-10-67. In January, **Blue Nishigaya** started the first week with B flight honors followed by **Richard Chun** who took B flight the following week. In the third week, **Roy Tanone** took individual medal and Richard tied in team best ball. **Kiku Kuramoto** and **Blue Nishigaya** shared B flight honors one afternoon and **Richard Chun** and **Tom Fujiwara** tied in B flight on another. We welcome our intrepid LSD investigator, **Bill Stevens** to the Hole-In-One Club. He used an 8 iron on the par 3 125-yd. first hole at the Hawaii Kai Country Club on February 1. We wonder if the "cosmic effect" from achieving the hole in one was as profound as that from LSD? Also in February, **Toots Fujii** tied for A flight honors with 36 points. We failed to see any news dispatches from the Oahu Country Club, but look for the winner of the HMA's annual tournament to hail from that club where the members received new higher handicaps when the new rating based on distance went into effect. At Ala Wai, scrambler **Ike Nadamoto** took 3rd place in A flight and **Dick Omura** repeated B flight honors while the year's most improved player **Tetsui Watanabe** won 2d place. **Paul Tamura** reluctantly left the Thursday Club to join the Waialae and bequeathed his berth to Ben Hogan's avid disciple, **Nobu Nakasone.**

*Fishermen:* We learned that **Harold Sexton** and **Jim Cherry** have installed twin 60 HP diesels in their do-it-yourself sport fishing cruisers which are nearing completion in a Kaneohe banana patch. Though they do look a little worn recently, we are constantly amazed that these two full-time practitioners have found the time necessary for their projects this whole past year. While Harold and Jim were slaving away, **Dick Landry** of Shriners was fishing off Makapuu in his little Boston Whaler and hauling in the ono and kawakawa. **Dick Sakimoto** in his haole sampan, the Kamome, has been reeling in 50-pound uluas and kahalas on his 20-pound-test spin tackle at the Banks. More recently, he has been nursing several broken ribs sustained on a fishing trip on January 15, but with spirits undaunted, he plans to resume his quest for those denizens of the briny deep in early March. **Ivar Larsen**, fishing from the Golden Marlin, landed a diminutive 25-pound natagi marlin while **Dick Landry** fishing alone on his T-Belle landed a 35-pounder after losing two earlier strikes.

*continued page 352*

### ROBERT PAK CHON HO, M.D.
### 1924-1967

Robert P. C. Ho was born in Honolulu on March 5, 1924, the son of Thomas and Helen (Kam) Ho. He graduated in 1942 with honors from Roosevelt High School, where he served as vice-president of the student body. He completed his undergraduate work at the University of Hawaii. In 1951, he graduated *magna cum laude* from the Temple University School of Medicine in Philadelphia where he won the Alumni Prize for attaining the highest grade average during his senior year. He was a member of Alpha Omega Alpha, an honorary medical society.

After interning at Williamsport General Hospital in Pennsylvania, Bob spent a year as an obstetrical resident at Temple University Hospital before the call of general practice became too irresistible. He became a practicing physician in Honolulu in 1953. His unselfish devotion and compassion for his patients made his medical practice a busy one. In spite of this, he was actively involved in the affairs of his community and of his profession. He was President of the Ho Society and a member of the standing committee of the United Church of Christ. He was a member of the Board of Governors of the Honolulu County Medical Society, a past president of the Hawaii Chapter of the American Academy of General Practice, Chief of General Practice at Children's Hospital, and a past president of the Medical Staff of St. Francis Hospital and was Chief of General Practice there at the time of his unexpected death from an acute heart attack on January 13, 1967, at the age of 42. He was also a delegate to the Hawaii Medical Association and a member of numerous state and county medical society committees.

The 111th annual meeting of the Hawaii Medical Association to be held in Honolulu May 17-21 will be a memorial to Bob. This year's scientific program will be the third consecutive one that he had planned and will outshine all previous programs—a reflection of the inspiration and perseverance he generated to this planning committee of which he was chairman.

He was also the ideal family physician. His patients looked to him as a doctor, counsellor, and a friend. He generated warmth, understanding, and confidence to all who have known him. He was also the ideal happy family man—a loving husband and a good father.

Bob is survived by his wife, Rose; a son, Nelson; four daughters, Janis, Karen, Valerie, and Jocelyn; his mother, Mrs. Helen Kam Ho; a brother, Roland; two sisters, Mrs. Howard (Esther) Lee and Mrs. Alfredo (Roberta) Urbien.

The passing of Dr. Robert P. C. Ho is a great loss to Hawaii medicine and this community. Although his life was short, his memory will live with us for a long time.

WILLIAM W. L. DANG, M.D.

# What a difference a good night's sleep makes



A good night's sleep and all's well with the world. A night of sleepless tossing and the day's pleasant moments lose their luster, routine tasks seem like grinding drudgery.

Count on Doriden to help make the difference. For most patients with insomnia, it provides a good night's sleep, a clear awakening.

# Doriden® (glutethimide CIBA)

**Doriden®** (glutethimide CIBA)

**Indications and Dosage:** *Insomnia*—0.5 Gm at bedtime. *Preoperative Sedation*—0.5 Gm the night before surgery; 0.5 to 1 Gm 1 hour before anesthesia. *Obstetric Sedation*—0.5 Gm at onset of labor.

Continuing total daily dosage over 1 Gm is not recommended.

**Caution:** Supervise dosage carefully, especially in patients with a known propensity for overdosing. Excessive and prolonged use in susceptible persons (e.g., alcoholics, former addicts, severe psychoneurotics) may result in dependence and withdrawal reactions. In those cases, reduce dosage gradually to lessen the likelihood of withdrawal reactions such as nausea, abdominal discomfort, tremors, or convulsions. Newborns of mothers dependent on glutethimide may exhibit withdrawal symptoms.

**Side Effects:** Occasionally, a skin rash may occur; if so, withdraw drug. The rash usually clears spontaneously in 2 or 3 days. Occasionally nausea also occurs. Rarely, acute hypersensitivity reactions and blood dyscrasias have been associated with glutethimide therapy.

**Supplied:** *Tablets*, 0.5 Gm (white, scored) and 0.25 Gm (white, scored); bottles of 100, 500 and 1000. *Tablets*, 0.125 Gm (white); bottles of 100. *Capsules*, 0.5 Gm (blue and white); bottles of 100.

*Consult complete literature before prescribing.* 2/3646 MBL

CIBA Pharmaceutical Company, Summit, N.J. CIBA



# Simplastin® is made with the patient in mind

**a patient on anticoagulant therapy is not "normal"**
Alone among thromboplastin reagents, Simplastin is reproducible not only in the normal range but also, and with equal assurance, in dilute plasma and in plasma from patients on anticoagulant therapy.

**a patient stays on anticoagulants for a long time**
Changes in prothrombin time should reflect changes in the patient and not variability of the test. Careful, continual control of the size and number of suspended particles assures the dependability of Simplastin in the therapeutic range and its reproducibility from vial to vial, lot to lot, test after test after test.

Available: 50-, 20- and 6-det. vials.

GENERAL DIAGNOSTICS Division Warner-Chilcott Laboratories, Morris Plains, N.J.

# HAWAII TECHNOLOGISTS' BULLETIN

*Official Publication of the Hawaii Society of Medical Technologists*

*Editor:* LOUISE WULFF, MT(ASCP), University of Hawaii

## *HSMT's Annual Convention—The Eighteenth*

HSMT members are looking forward to another exciting three days of lectures, workshops, exhibits, good food, and fellowship. This year's activities will be held at the Princess Kaiulani Hotel on May 25, 26, and 27. Final arrangements will be announced later, but here is a brief summary of the activities Dorothy Matsuo's committee is planning:

*Workshop:* Difco will present a workshop on serological identification of bacteria.

*Lecturers:* Dr. Richard Blaisdell, Dr. N. V. Bhagavan, Dr. Edwin Nishimura, and Dr. Ralph Platou.

*Exhibits:* Besides their exhibits of general interest, several companies will show some of their special new equipment and demonstrate laboratory applications in some detail.

*The Banquet:* Held at the Princess Kaiulani. Entertainment will be provided by those automated, motivated young adults—the students!

## *Automation—Continued*

Automation is already here and almost every lab of any significant size has at its disposal various forms of equipment designed to do automatically a variety of procedures and do them faster, more accurately, and on a smaller specimen sample than by the traditional hand methods. Much of the available equipment presently does not require a great deal of specialized knowledge but rather careful attention to control and a suspicious mind that will not accept an answer as valid just because it has been produced by a machine.

The Technicon Autoanalyzer presently is the standard piece of automated equipment used in clinical chemistry. Their recently marketed SMA-12 model, which performs 12 analyses simultaneously, is a marked improvement over the 8-channel unit developed for the Kaiser Hospital multiphasic screening examination and it is also over the original 12-channel pilot models tried in several hospitals. Several units are on order for this State and laboratory personnel are already dividing into camps. Those who have ordered the 12-channel model feel that the equipment will prove far more useful than anyone can imagine and that they can work out some of the inherent difficulties that come with any complicated piece of mechanical and electronic equipment.

Those who have purchased other types of automated equipment feel that they do not want to put all of their eggs into a single 12-channel basket. When there is a breakdown, a large segment of the chemistry department is under repair. They claim that the 12-channel equipment is wasteful of expensive reagents and requires a long time to warm up and balance each day. Also, this is not a machine that one can set and forget. It requires the full-time attention of one and possibly two technologists. To make 12 determinations of varying degrees of complexity, which take various times to develop full, stable color production, and arrive at the spectrophotometer simultaneously to be read, is no mean feat. Slight variations in tube size due to temperature or pressure changes can speed or delay the passage of any one channel through the apparatus. Also, there is a definite question in the minds of some pathologists and chemists as to whether or not some of the chemical methods have been compromised on the 12-channel machine for the sake of simultaneous determinations. As experience is gained, there will certainly be some alterations and improvements.

Warner-Chilcott acquired several research specialty companies several years ago and has just brought to fruition the Robot Chemist. This is a completely revamped and far more sophisticated model of the first Robot Chemist, which failed to live up to its name. The current model is truly a mechanical technologist, which pipets serum into test tubes, adds reagents, incubates, and reads out the results in a spectrophotometer. A computer accessory translates and reports OD units or milligrams per cent. This is an entirely different concept from the Autoanalyzer, in that it is using aliquot chemistry in which each specimen is being handled separately by time-tested methods. The reliability of the electronics of the equipment is yet to be proved. There are many panel boards and electronic controls which, without specially trained service by electronic technicians, might incapacitate the machine for days at a time. This is a problem which can be overcome in this age of air freight and is certainly not unique to the Robot Chemist.

Another new piece of equipment is the Hycel Mark X. This is just being marketed and very little is known about the equipment or the methods

EDITOR'S NOTE: Since we hope that our considerations of automation and its effect on medical technologists now and in the future will be in some depth, we thought it might be a good idea to look at the machines themselves. Pathologist Richard R. Kelley, at The Queen's Hospital, has worked extensively with automated chemistry and presents here a brief look at three types of laboratory automated equipment.

that it uses. It will be at least six months to a year before an adequate evaluation of this piece of equipment is available.

Currently available equipment is already making possible the "biochemical screen," that is, 10 or 12 selected biochemical determinations performed as part of an annual physical examination or upon admission to the hospital. Several hospitals in other states are making this mandatory for all adults admitted. A recently presented survey of the results of biochemical screens done on all admissions in a community hospital showed that a significant number of additional clinical chemical abnormalities were easily detected. The number of these abnormalities that are truly unsuspected and have clinical significance is difficult to evaluate. From his data, Bryan[1] estimates that ordinarily unrequested information available through a routine biochemical screen can be of benefit to between five and ten per cent of hospital admissions. The unexpected findings also can result in earlier institution of appropriate therapy and hopefully shorter hospital stays. Almost everyone who has been performing biochemical screens routinely can cite cases where surgery has been postponed following the detection of unsuspected hepatic disease, renal disease, or cardiac disease.

Automation is not only helping the laboratory keep its prices stable in the face of inflationary costs; in some instances, it is allowing drastic reductions in the laboratory fee schedule. In fact, a whole new concept must be developed to recognize that there is a difference between the cost of a single laboratory determination run at the convenience of the patient, and one run as part of a panel at the convenience of the laboratory. Also being recognized is that the cost of collecting a sample, reporting, and billing the patient should be considered separately from the cost of performing the examination. These problems are being worked out, and the result will be a better value for the patient.

The future will see a tremendous development in the field of laboratory automation. Computers will be used to fill the gap that exists between the time laboratory data is available on the spectrophotometer readout device, and the moment it is communicated to the physician. Pilot studies have already indicated that it is feasible to have a direct linkage through a computer from the spectrophotometer to a typewriter or other reporting device located in the doctor's office, on the nursing floor, or even at the patient's bedside.

Traditional methods of wet chemistry will be supplemented or eventually replaced by atomic absorption, x-ray spectroscopy, and gas chromatography, though available equipment in these fields has not yet been adapted to automation in the same way as methods in wet chemistry. This may come in a very short period of time.

[1] Bryan, D. J., Wearne, J. L., Viau, A., Musser, A. W., Schoonmaker, F. W., and Thiers, R. E.: Profile of Admission Chemical Data by Multichannel Automation: An Evaluative Experiment. Automation in Analytic Chemistry: Technicon Symposia, Page 423, 1965.

What does this hold for the technologist? It means that many technologists will be relieved from routine tasks and can devote their time to areas that use their skills more effectively. It also means a need for continual self-education in the use of automated equipment. Technologists are going to have to become knowledgeable in electronics and computers. Courses in both theory and practical application in these fields should be offered locally both for technology students and for those who already have their licenses. The response of this latter group will separate those who look upon medical technology as just another job from those who are dedicated to it as a professional pursuit. Medicine needs those who can meet the challenge.

RICHARD R. KELLEY, M.D.

## *Automation: Various Views from HSMT Members*

FROM THE BLOOD BANKS

Certainly one is skeptical about allowing machines to make decisions on blood types but when automation has been rigorously tested perhaps we can hope for a better system than trying to control the "human factor."

Miss Ann Stegmaier MT(ASCP) from the Honolulu Blood Bank found these facts for us and submitted the following report.

ABO blood groupings by the Autoanalyzer was first reported in 1963 when 100 tests using Anti A and Anti B were performed in either hours.[1] During this same year other workers extended the use of the Autoanalyzer and were able to perform ABO grouping of cells and serum at the rate of 40 per hour.[2] Modifications have been made and at the present time the manufacturer reports that with a nine-channel system for ABO and Rh typings, 120 groups can be done in an hour.

The average number of donors processed and released daily at the Blood Bank of Hawaii is 75; and the maximum number of units that can be released during an eight-hour period is 200. This relatively small volume of work does not seem to justify the use of the Autoanalyzer in the processing of donor blood in Hawaii.

Research and blood donor centers in large U.S. cities, such as New York and Los Angeles, are presently using the Autoanalyzer—with special interest in antibody screening tests—with apparent superior results over the currently approved methods now utilized here in Hawaii, by having a central antibody-screening laboratory where *all* prenatal and transfusion and surgical patients in Hawaii would be submitted for sampling in the Autoanalyzer. Further reports from groups working on this phase may possibly justify consideration of the use of the Autoanalyzer in at least this one area of blood-banking here in Hawaii some time in the future. ■

[1] McNeil, Helmick, and Ferrari: Vox Sanguinis 8:235 241 (1963).
[2] Cedergren & McQuiston: Vox Sanguinis 8:438-451 (1963).





Posed by professional model

# I'm supposed to get up and do things?

# With my heart?

It's entirely natural—and may even be desirable—for the cardiovascular patient to be somewhat anxious about himself.

But when anxiety leads to unreasonable self-imposed limitations and restrictions . . . when it aggravates cardiovascular symptoms . . . when it interferes with restful sleep, measures to help alleviate the anxiety are probably in order.

One measure, of course, is reassurance. Another, adjunctive measure, is EQUANIL (meprobamate).

Over a decade of experience has shown that EQUANIL (meprobamate) is generally well tolerated as well as effective. Side effects are usually limited to transient drowsiness; serious, therapy-interrupting side effects are rare.

**Cautions:** Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use may result in dependence or habituation in susceptible persons—as ex-addicts, alcoholics, severe psychoneurotics. After prolonged high dosage, drug should be withdrawn gradually to avoid possibly severe withdrawal reactions including epileptiform seizures. Side effects include drowsiness and, rarely, allergic or idiosyncratic reactions. These reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Mild reactions are characterized by urticarial or erythematous maculopapular rash. Acute non-thrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever have been reported. Meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioneurotic edema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. Warn patients of possible reduced alcohol tolerance. Should drowsiness, ataxia, or visual disturbances occur, dose should be reduced. If symptoms persist, patients should not operate vehicles or dangerous machinery. A few cases of leukopenia, usually transient, have been reported following prolonged dosage. Other blood dyscrasias—aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis and hemolytic anemia—have occurred rarely, almost always in the presence of known toxic agents. One fatal case of bullous dermatitis following intermittent use of meprobamate with prednisolone has been reported. Prescribe very cautiously for patients with suicidal tendencies. Suicidal attempts should be treated with immediate gastric lavage and appropriate supportive therapy.

**Contraindications:** History of sensitivity to meprobamate.

**Composition:** Tablets, 200 mg. and 400 mg. meprobamate. Coated Tablets, WYSEALS® EQUANIL (meprobamate) 400 mg. Continuous-Release Capsules, EQUANIL L-A (meprobamate) 400 mg.

**American Hospital Formulary Service Category No. 28:16.08**

A quality controlled product of
Wyeth Laboratories Philadelphia, Pa.

**to help relieve anxiety and tension occurring alone or secondary to organic disease**

Equanil® (meprobamate)

Wyeth® SERVICE TO MEDICINE

**the usual fee charged to nonmembers on all other copies.**

**It was voted that the Department of Social Services be given permission to reproduce the HRVS.**

## REPORT OF THE SECRETARY

The Secretary's four recommendations were discussed and acted upon as follows:

**ACTION:**

**It was voted to approve all the membership changes reported by the counties and that the roster of the HMA be set as indicated for December 31, 1966.**

**It was voted that the HMA wait until further information is received from Hawaii County relative to the matter of nontransmittal of dues of Verne L. Adams, Reginald S. Cravalho, Fred L. Goff, and Harry A. Lee.**

**It was voted that the counties receive a list of the doctors the AMA reports as not having paid their dues and information be sought to determine if the counties have any program for encouraging medical society membership for nonaffiliated physicians.**

**It was voted that Dr. Bjornson's status on the committees on which he serves be maintained until his membership is cleared through his county society.**

## REPORT OF THE TREASURER

The Treasurer's report was discussed and acted upon as follows:

**ACTION:**

**It was voted that the members of the Council who must travel from another island to attend Council meetings have their per diem increased to $30 or be reimbursed up to that amount.**

**It was voted that the cost for lunches served at committee meetings be paid for by the HMA, not to exceed $1.25 per member or guest.**

**It was voted that Dr. T. Tomita be reimbursed fully for all expenses incurred on his trip to the AMA Clinical meeting last November.**

**It was voted that the audited figures as presented in this report be published with the minutes of the JOURNAL.**

There was considerable discussion about the HMA paying in full all expenses for the President, President-Elect, Delegate, and Alternate Delegate to AMA Annual and Clinical Sessions. It was recommended that the Treasurer include this in the preparation of his budget for next fiscal year.

**ACTION:**

**It was voted that the Treasurer include in his budget for the next fiscal year the expenses of the President, President-Elect, Delegate, and Alternate Delegate to the AMA Annual and Clinical Sessions.**

## AUDITOR'S REPORT

### GENERAL FUND

| | June 30 1966 | June 30 1965 |
|---|---|---|
| ASSETS | | |
| Cash on hand and in bank | $ 2,303.60 | $ 2,927.42 |
| Cash on deposit in various Savings & Loan Associations | 74,167.57 | 79,681.32 |
| Due from American Medical Association | 2,608.74 | 2,624.34 |
| Due from Lauren Production | 520.00 | ..... |
| Other receivables | 84.41 | ..... |
| Advance to employees' Pension Fund Trustee | 100.00 | 89.36 |
| Furniture, Fixtures & Equipment, at cost | 10,079.74 | 9,479.74 |
| TOTAL ASSETS | $89,864.06 | $94,802.18 |
| LIABILITIES | | |
| Accounts Payable | $ ..... | $ 5,352.28 |
| Accrued Payroll Taxes | 808.63 | 544.26 |
| Due Mental Health Committee | 1,660.00 | ..... |
| Advances from American Cancer Society and State of Hawaii Department of Health on Anti-Smoking Program | 1,184.92 | ..... |
| Due Scientific Meetings | 300.00 | 300.00 |
| Due Golf Committee | 16.89 | 105.73 |
| Due Tennis Committee | 14.12 | ..... |
| Advances on Mental Health Fair | ..... | 5,000.00 |
| Due Public Relations Committee | ..... | 200.00 |
| TOTAL LIABILITIES | 3,984.56 | 11,502.27 |
| GENERAL FUND BALANCE | 85,879.50 | 83,299.91 |
| TOTAL LIABILITIES & GENERAL FUND BALANCE | $89,864.06 | $94,802.18 |

### PHYSICIANS' BENEVOLENT FUND

| | June 30 1966 | June 30 1965 |
|---|---|---|
| ASSETS | | |
| Cash on deposit in various Savings & Loan Associations | $26,023.57 | $23,287.13 |

### EMPLOYEES' PENSION PLAN FUND

| | | |
|---|---|---|
| ASSETS | | |
| Cash Balance | $ 257.68 | $ ..... |
| International Savings and Loan | 500.00 | ..... |
| Hawaiian Trust Co., Ltd., Contract Equity Fund | 2,188.15 | ..... |
| Hawaiian Trust Co., Ltd., Contract Fixes Income Fund | 3,778.55 | ..... |
| TOTAL ASSETS | $ 6,724.38 | $ ..... |
| LIABILITIES | | |
| Deposit—Advanced by Hawaii Medical Association | $ 100.00 | $ ..... |
| MEMBERS' EQUITY | 6,624.38 | ..... |
| TOTAL LIABILITIES & MEMBERS' EQUITY | $ 6,724.38 | $ ..... |

The income and expenses for the 12 months ending June 30, 1966, as audited were as follows:

*continued page 338*



**BLEMISHES?**

COVERMARK conceals all skin discolorations . . . birthmarks, brown & white patches, broken veins, tattoos, burns, scars, on any part of the body. COVERMARK is also unexcelled as an overall makeup . . . will not rub or flake off. Waterproof and Sunproof.

*Lydia O'Leary*

**OF HAWAII**

ALA MOANA CENTER—STREET LEVEL

PHONE 993-288

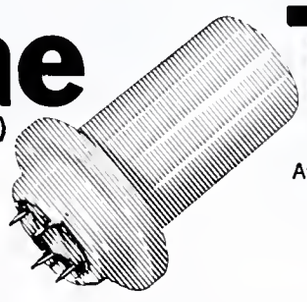
# what time is it?

For the past
two years
there's been
one new case
of active tuberculosis
reported for every
four thousand
of U.S. population.

# it's time to tine.

## Tuberculin, Tine Test

(Rosenthal) Lederle



Available in 5's and 25's.
Order now
from your pharmacist
or your Lederle
representative.

LEDERLE LABORATORIES, A Division of American Cyanamid Company, Pearl River, New York

414-6—4046R



*"George wants to know if it's okay to take his cold medicine now, Doctor, instead of seven o'clock?"*



The long-continued action of Novahistine LP should help you both get a good night's sleep. Two tablets in the morning and two in the evening will usually provide round-the-clock relief by helping clear congested air passages for freer breathing. Novahistine LP also helps restore normal mucus secretion and ciliary activity—normal physiologic defenses against infection of the respiratory tract. Use cautiously in individuals with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result. Each Novahistine LP tablet contains: phenylephrine hydrochloride, 25 mg., and chlorpheniramine maleate, 4 mg.

# NOVAHISTINE® LP

DOW **PITMAN-MOORE** Division of The Dow Chemical Company, Indianapolis

Have fun at all FIVE
Sheraton Hotels
in Hawaii

THE Royal Hawaiian



MONARCH ROOM / SURF ROOM

THE Moana



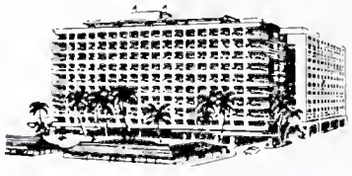
BANYAN COURT / KAMAAINA BAR

THE Surf Rider



CAPTAIN'S GALLEY / CAPTAIN COOK ROOM

THE Princess KAIULANI



PIKAKE TERRACE / KAHILI LOUNGE

THE SHERATON—MAUI



DISCOVERY ROOM / BARKENTINE BAR & TERRACE


## *Hawaii Medical Association* *continued from 334*

| | |
|---|---|
| INCOME: | |
| Members' Dues | $67,419.50 |
| Interest Income from various Savings & Loan Associations | 3,131.03 |
| Miscellaneous Income | 840.24 |
| Annual Meeting—Net | 6,830.22 |
| Annual Roster—Net | (5,301.93) |
| Less JOURNAL Reimbursements | (1,148.00) |
| TOTAL INCOME | $71,771.06 |
| LESS GENERAL & ADMINISTRATIVE EXPENSES: | |
| Salaries and Wages | $28,999.38 |
| Public Relations and Health Education Committee | 10,039.70 |
| Legislative Committee | 5,784.10 |
| Woman's Auxiliary | 3,377.50 |
| Rent | 3,168.00 |
| Convention Expenses | 2,673.37 |
| Audit, Accounting and Legal Services | 2,275.00 |
| Postage | 1,901.85 |
| Supplies, Stationery and Printing | 1,652.32 |
| Telephone and Cable | 1,504.83 |
| Taxes | 1,302.80 |
| Health Planning Facilities Committee | 1,000.00 |
| Medicare Plans and Fee Committee | 899.90 |
| Subscriptions and Dues | 880.05 |
| Travel | 812.06 |
| Council Meeting Expenses | 786.51 |
| Automobile Allowances | 590.00 |
| Insurance | 510.59 |
| Pension Plan—Actuary Fee | 500.00 |
| Entertainment | 413.91 |
| Miscellaneous Expenses | 302.68 |
| Repairs & Maintenance | 201.37 |
| Careers Committee Expenses | 187.07 |
| Hawaiian Academy of Science | 150.00 |
| Interest Expense | 144.78 |
| Maternal & Prenatal Mortality Study | 139.20 |
| Library Contribution | 100.00 |
| Donations | 20.00 |
| TOTAL GENERAL & ADMINISTRATIVE EXPENSES | $74,316.97 |
| Less JOURNAL Reimbursements | (7,020.00) |
| NET GENERAL & ADMINISTRATIVE EXPENSES | $63,296.97 |
| NET INCOME BEFORE EMPLOYEES' PENSION PLAN CONTRIBUTION | $ 8,474.09 |
| Less Employees' Pension Plan Contribution | 2,500.00 |
| NET INCOME | $ 5,974.09 |

### REPORT OF COMMITTEES AND COMMISSIONS

*Nominating Committee:* This Committee met an hour prior to the Council meeting and presented its slate. At the time of this Council Meeting, the nominees had not been contacted to see if they would accept the nominations. There was discussion about sending the slate back to the Nominating Committee for reconsideration. The Chair ruled that the Nominating Committee report stand until the time the House of Delegates meets.

*Bureau of Planning and Research:* This Committee is asking Council approval to seek outside funds to pay for the services of an authority trained in analyzing the medical care of communities to study medical care as it exists and is developing in Hawaii.

**ACTION:**

**It was voted that the Council approve the request of the Bureau of Planning and Research.**

*AMA-ERF:* This Committee is trying to raise funds and stimulate more interest. A display and brochures have been ordered for the Annual Meeting. It was noted that funds raised for AMA-ERF is directed along basic science research. It was suggested that the HMA advise its Delegate to urge the AMA to give some of his money to patient care and not only to basic sciences.

*Medical Education:* This Committee is asking for Council confirmation of the policy it developed relative to University professors. The Committee's motion reads as follows: "Under the present organization of the University of Hawaii Medical School, the Medical Education Committee of the HMA voted to go on record favoring the full-time faculty members be allowed to engage in a limited physician referral consultation practice; that the consultants should charge a reasonable fee; and that the

*continued page 344*

# Any good hypoallergenic formula can protect the allergic child

## (but now, there's more to the picture!)





# Hypoallergenic ProSobee® protects and provides the extra benefits of these milk-like qualities:



**1. More natural stool patterns.** The stool patterns of infants on ProSobee formula resemble those of infants on milk-based formula. There is no offensive odor, no major variance in color, no tendency to looseness, and no unfamiliar staining of diapers. Nothing to alarm the mother... nothing to impel a "worry" telephone call.

**2. Natural appearance and consistency.** New, milk-like ProSobee formula makes the transition to a hypoallergenic nutritional less troublesome than ever before. There's no coffee color, no "beany" aroma. No nipple-clogging coarseness, either! ProSobee utilizes a new soy-protein isolate which eliminates the negative properties associated with most soybean formulas.

With ProSobee formula, feeding time remains a pleasant experience... uncomplicated by a mother's possible aversions (which may be communicated to the sensitive infant).

**3. And good nutrition, naturally!** The protein efficiency value of ProSobee formula closely approaches that of casein, and is higher than values found in whole soy flour formula. Further, in a recent study* (where the positive antigenicity of soy flour and two commercially available soybean infant formulas was shown), highly potent rabbit antisera produced *no precipitin bands* against ProSobee formula. It is truly hypoallergenic!

*Crawford, L. V., et al.: Ann. Allergy *23*:303 (July) 1965.

ProSobee is a trademark of Mead Johnson & Company. © 1966, M. J. & Co.

**ProSobee®**

MILK-FREE FORMULA WITH SOY ISOLATE

Mead Johnson LABORATORIES

*Research for Life*

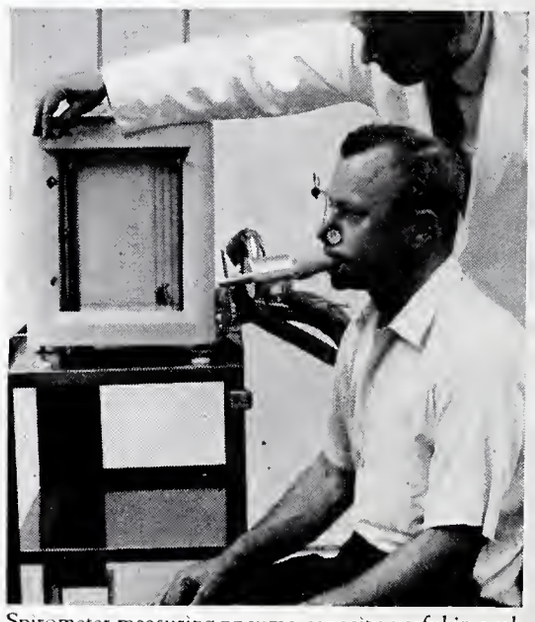
# In chronic respiratory infections:



Diffused mottling in lower right lobe consistent with bronchopneumonia.



Direct bronchoscopy reveals a chronic inflammatory response.



Spirometer measuring pneumo-capacity, useful in evaluating degree of emphysema.

# You can minimize recurrence with this single bactericidal broad-spectrum agent.

Now, instead of tetracycline, penicillin-streptomycin or chloramphenicol, you can use a single broad-spectrum antibiotic—Polycillin (ampicillin trihydrate)—against bacterial infections in pulmonary emphysema, chronic bronchitis and pneumonia.[1-6] Bactericidal against *D. pneumoniae*, Polycillin (ampicillin trihydrate) is also more active than tetracycline or chloramphenicol against *H. influenzae* and many other Gram-negative pathogens. It is well tolerated and without direct toxicity in high or prolonged dosage.

Chronic bronchitis, where pneumococci often accompany the predominant *H. influenzae*, is thus a major indication for Polycillin (ampicillin trihydrate).[4] And when pneumococci are the sole pathogens, controlled clinical trial has shown that it can produce early defervescence more often than parenteral penicillin-streptomycin.[5] While Polycillin (ampicillin trihydrate) cannot reverse structural pathology, it does offer a new and practical way to minimize the chronicity of associated bacterial respiratory infection.

References: 1. May, J. R.: Postgrad. M. J. *40*:193, Suppl., (Dec.) 1964. 2. Millard, F.J.C.: Geriatrics *20*:854 (Oct.) 1965. 3. Lyons, H.A.: M.Times *93*:1386 (Dec.) 1965. 4. Council on Drugs: JAMA *191*:1071 (Mar. 29) 1965. 5. Crofton, J.W., *et al.*: Brit. M.J. *1*:1329 (May 28) 1966. 6. Lyons, H.A.: JAMA *194*:1234 (Dec. 13) 1965.

BRISTOL

BRISTOL LABORATORIES/Division of Bristol-Myers Co. Syracuse, New York

PRESCRIBING INFORMATION. For complete information consult Official Package Circular. *Indications:* Infections due to susceptible strains of Gram-negative bacteria (including Shigellae, *S. typhosa* and other Salmonellae, *E. coli*, *H. influenzae*, *P. mirabilis*, *N. gonorrhoeae* and *N. meningitidis*) and Gram-positive bacteria (including streptococci, pneumococci and nonpenicillinase-producing staphylococci). *Contraindications:* A history of allergic reactions to penicillin and infections due to penicillinase-producing organisms. *Precautions:* Typical penicillin-allergic reactions may occur, especially in hypersensitive patients. Mycotic or bacterial superinfections may occur. Experience in newborn and premature infants is limited and caution should be used in treatment, with frequent organ function evaluations. Safety for use in pregnancy is not established. In gonorrheal therapy, serologic tests for syphilis should be performed initially and monthly for 3 months. Assess renal, hepatic and hematopoietic function intermittently during long-term therapy. *Adverse Reactions:* Skin rash, pruritus, urticaria, nausea, vomiting, diarrhea and anaphylactic reactions. Mild transient elevations of SGOT or SGPT have been noted. *Usual Dosage:* Adults —250 or 500 mg. *q.* 6 *h.* (according to infection site and offending organisms). Children—50-100 mg./Kg./day in 3 to 4 divided doses (depending on infection site and offending organisms). Children weighing more than 20 Kg. should be given an adult dose. Beta-hemolytic streptococcal infections should be treated for at least 10 days. *Supplied:* Capsules—250 mg. in bottles of 24 and 100. 500 mg. in bottles of 16. For Oral Suspension—125 mg./5 ml. in 60, 80, and 150 ml. bottles. 250 mg./5 ml. in 80 ml. bottles. Injectable—for I.M./I.V. use—vials of 125 mg., 250 mg., 500 mg., and 1 Gm.

A.H.F.S. Category 8:12.16

**Polycillin®**
(ampicillin trihydrate)

the penicillin you use like a broad-spectrum antibiotic

disposition of this fee be left to the administration of the medical school."

**ACTION:**

**It was voted that the President be empowered to refer this matter to the proper committee to study it in depth and report back at the next Council meeting.**

The Council was asked to approve sending the Chairman of the Medical Education Committee to the 63rd Congress of Medical Education in Chicago on February 12 and 13, 1967.

**ACTION:**

**It was voted that the Council approve to send the Chairman of the Medical Education Committee to the conference and have him report back to the Council.**

An error in the Commissioner's report was called to the attention of the Council in that the Committee has not made the recommendation that present methods of teaching need not be maintained.

*Arrangements:* At the Committee's January 31 meeting the matter of waiver of registration fees was discussed. The following decisions were made by the Council.

**ACTION:**

**It was voted that the visiting pathologists who are accompanying Dr. Auerbach on the lung cancer study and who are listed on the program pay the $35.00 registration fee for the scientific session.**

**It was voted that any physician or Ph.D. participating in the scientific session as a speaker have his registration fee waived.**

**It was voted that the University students' registration fees be waived provided they are properly endorsed by their department heads in genetics and biomedical science.**

**It was voted that University professors not M.D.'s, University professors who are M.D.'s, and Department of Health M.D.'s who are not members of the HMA be required to pay the usual registration fee for nonmembers.**

**It was voted that the registration fee for Phyllis Wright, M.D., who will be asked to help assemble clinical material, be waived.**

**It was voted that the registration fee for Hawaii interns and residents be waived.**

**It was voted to waive the registration fee of interns and residents from out of state provided they have a letter from their Chief of Staff.**

**It was voted that the active military M.D.'s registration fee be cut in half.**

**It was voted that registration fee for ministers be waived.**

**It was voted that registration fee for nurses be waived.**

*Heart:* The Committee met on January 27 and would like Council confirmation on its actions relative to (1) approval of the minimum standards as set forth by the Hawaii Heart Association for cardiovascular clinics, and (2) going on record as backing the drug project outlined in the communication from the Straub Research Foundation.

**ACTION:**

**It was voted that the Council approve the minimum standards set forth by the Hawaii Heart Association for cardiovascular clinics.**

**It was voted that the Council go on record as backing the drug project outlined in the communication from the Straub Research Foundation.**

*continued page 348*

**MEDICAL PLACEMENT BUREAU and NURSES' REGISTRY**

24 Hour Service

**LET US SERVE YOU IN YOUR NEED**

Nurses, Staff and Office
Nurses, Private Duty
Nurses, Supervisors
Practical Nurses
Nurses, Aide
Dental Assistants
Physical Therapists
X-Ray Technicians
Laboratory Technicians
Medical Stenographers
Medical Clerks
Receptionists
Male Nurses
Bookkeepers
Home Companions

Frieda M. Beezley, R.N., *Director*

**1473 South King St.** **991-237**

**WHEN YOU HAVE A CALL TO MAKE ... CALL HAWAIIAN AIRLINES FOR CONVENIENT JET FLIGHTS TO ALL ISLANDS WHETHER FOR BUSINESS OR PLEASURE**

**FOR RESERVATIONS CALL:**

| HONOLULU | KAHULUI | LANAI |
|---|---|---|
| 817-611 | 75-011 | 3-222 |
| HANA | KAMUELA | LIHUE |
| 442-483 | 858-505 | 2-751 |
| HILO | KONA | MOLOKAI |
| 50-811 | 256-465 | 37-475 |

**HAWAIIAN AIRLINES**

Holder of the World's Safety Record

# A Building Block approach to treating hypertension

**With these three therapeutic building blocks you can create a once-a-day regimen to fit almost any degree of hypertension. See the following pages for details . . .**



# Consider starting your hypertensives on this basic thiazide

**Enduron eliminates sodium around the clock, yet is relatively sparing of potassium**

Enduron is a true 24-hour single-dose thiazide. Its sodium excretion is not squeezed into an abrupt peak during the first several hours. It is well-sustained in a plateau-like effect — with little reduction in intensity during the first 12 hours, and decline thereafter only gradual.

Potassium loss, in contrast, reaches an early minor peak. Then it subsides rapidly. Moreover, doses larger than 5 mg. have little added effect on potassium. Thus doubling the dose from 5 to 10 mg. approximately doubles sodium excretion—yet increases potassium loss little or none.

Use Enduron once a day as an ideal starting therapy in mild hypertension. Use it, too, as a basic therapeutic building block with which other agents can be joined, for managing your more resistant hypertensives.

*Once a day, every day*

ENDURON®
METHYCLOTHIAZIDE




| DAILY DOSAGE RANGE | Minimum | Usual | Intermediate | Maximum |
|---|---|---|---|---|
| | 2.5 mg. tablet | 5 mg. tablet | 7.5 mg. | 10 mg. |

*See Brief Summary on final page of advertisement.*

# To build added response, shift to Enduronyl

**The deserpidine component compares favorably to reserpine, but with reduced side effects**

The rauwolfia component of Enduronyl is deserpidine (Harmonyl®), a purified crystalline alkaloid. It is comparable to reserpine in its antihypertensive and tranquilizing activity. Yet it produces less tendency toward typical rauwolfia side effects such as drowsiness, lethargy, stuffy nose, depression, etc.

Patient acceptance has been excellent.

Enduronyl comes in two strengths: regular and Forte. Both provide 5 mg. of Enduron. The variation is where most needed: in the deserpidine. These scored tablets give a surprisingly flexible choice of doses (see below).

Use Enduronyl for your patients within the broad range of mild to moderate hypertension. Dosage is *once* a day: this means Enduronyl will generally cost patients less than equivalent drugs taken two or three times daily.




*Once a day, every day*

## ENDURONYL®

METHYCLOTHIAZIDE 5 MG. WITH DESERPIDINE 0.25 MG.

## ENDURONYL FORTE

METHYCLOTHIAZIDE 5 MG. WITH DESERPIDINE 0.5 MG.

| | Minimum | Usual | Intermediate | Maximum |
|---|---|---|---|---|
| DAILY DOSAGE RANGE | 2.5 mg. methyclothiazide<br>0.125 mg. deserpidine | 5 mg. methyclothiazide<br>0.25 mg. deserpidine | 7.5 mg. methyclothiazide<br>0.375 mg. deserpidine | 10 mg. methyclothiazide<br>0.5 mg. deserpidine |
| DAILY DOSAGE RANGE | 2.5 mg. methyclothiazide<br>0.25 mg. deserpidine | 5 mg. methyclothiazide<br>0.5 mg. deserpidine | 7.5 mg. methyclothiazide<br>0.75 mg. deserpidine | 10 mg. methyclothiazide<br>1 mg. deserpidine |

*See Brief Summary on final page of advertisement.*

# Eutonyl affords a different kind of basic therapy for moderate to severe cases

ABBOTT

**Effect tied to reduced peripheral vascular resistance; no central depressant action**

Eutonyl is a unique nonhydrazine agent. It is reported to act by reducing peripheral vascular resistance, with little or no effect upon cardiac output.[1,2]

In clinical trials, significant reductions in mean blood pressure were seen in 84% of patients studied — including some unusually difficult cases. Eutonyl lowers diastolic in proportion to systolic, and in half of the cases studied, reductions in the sitting and recumbent positions were nearly as great as in the standing position.

Most important: There is no central depressant action. In fact, many patients reported an *increased* sense of well being.

Here, then, is a highly effective *basic treatment* for moderate to severe cases—and one that will not hamper your patient with lethargy or drowsiness while on treatment.

*Once a day, every day*

EUTONYL®
PARGYLINE HYDROCHLORIDE




| DAILY DOSAGE RANGE | Minimum | Usual starting | Intermediate | Maximum |
|---|---|---|---|---|
| | 10 mg. tablet | 25 mg. tablet | 50 mg. tablet or as needed | 200 mg. |


1. Brest, A. N., et al., Cardiac and Renal Hemodynamic Response to Pargyline, Ann. N. Y. Acad. Sci., 107-1016, 1963.
2. Winsor, T., Pargyline Hydrochloride, Hypertension, Urinary Tryptamine, and Vascular Reflexes, Geriatrics, 19:598, Aug., 1964.


*See Brief Summary on final page of advertisement.*

# Eutron adds thiazide for enhanced therapy with milder side effects

**Only a 7/4 mm. span between standing and recumbent pressures—reduced chance of orthastatic hypotension**

The combining of Eutonyl and Enduron in Eutron permits a significantly greater antihypertensive effect than with either agent used alone. This in turn may allow therapeutic success with lesser dosage—and correspondingly milder side effects.

Indeed, fully 94.5% of all patients studied during clinical trials continued on therapy uninterrupted by side effects.

Most striking was the drug's action in lowering blood pressure to *nearly equal levels in all body positions*. Total average spread between standing and recumbent readings (after treatment) was only 7/4 mm. Hg.

Thus, in your moderate to severe cases, Eutron affords a usually smooth course of therapy, with reduced likelihood of orthostatic effects. And, because of the thiazide component, Eutron may be used in the presence of congestive heart failure.

*Once a day, every day*

## EUTRON™

PARGYLINE HYDROCHLORIDE 25 MG.
WITH METHYCLOTHIAZIDE 5 MG.




| | Minimum | Usual starting | Intermediate | Maximum |
|---|---|---|---|---|
| DAILY DOSAGE RANGE | 12.5 mg. pargyline hydrochloride and 2.5 mg. methyclothiazide | 25 mg. pargyline hydrochloride and 5 mg. methyclothiazide | 37.5 mg. pargyline hydrochloride and 7.5 mg. methyclothiazide | 50 mg. pargyline hydrochloride and 10 mg. methyclothiazide |

*See Brief Summary on final page of advertisement.*

TM—Trademark

704075

# ENDURON®
METHYCLOTHIAZIDE

# ENDURONYL®
Each tablet contains Methyclothiazide 5 mg.
with Deserpidine 0.25 mg. or 0.5 mg.

*Indications:* Enduron is used to control edema and mild hypertension. Also used with other drugs for hypertension. Enduronyl is used in mild to moderately severe hypertension.

*Contraindications:* Neither Enduron nor Enduronyl should be used in severe renal disease (except nephrosis) or shutdown; in severe hepatic disease or impending hepatic coma; in patients sensitive to thiazides. Enduronyl is contraindicated in severe mental depression, active peptic ulcer, and ulcerative colitis.

*Warnings:* Consider possible sensitivity reactions in patients with a history of allergy or asthma. Avoid use of enteric-coated potassium tablets, as these may induce serious or fatal small bowel lesions; if added potassium intake is desired, dietary supplementation is recommended. Coated potassium tablets should be reserved for cautious use when adequate dietary supplementation is impractical.

*Precautions and Adverse Reactions:* Use thiazides with caution in severe renal dysfunction. Caution is also necessary with impaired hepatic function or progressive liver disease. During intensive or prolonged thiazide therapy, watch chloride and potassium levels (especially the latter if patient is on digitalis). In surgical patients, thiazides may alter response to vasopressors and tubocurarine. Use thiazides with caution in pregnancy (bone marrow depression, thrombocytopenia, or altered carbohydrate metabolism are possible in certain newborn). Occasional thiazide side effects also include blood dyscrasias; elevations of BUN, serum uric acid, or blood sugar; electrolyte imbalance, g.i. disturbances, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice, pancreatitis, and gout.

Use Enduronyl with caution in patients with a history of peptic ulcer, as rauwolfias may increase gastric secretion. Discontinue at the first sign of mental depression. Rauwolfias may increase hypotensive effects of surgery or anesthesia, and are best discontinued two weeks prior. They also lower the convulsive threshold in epilepsy. Other possible rauwolfia side effects include drowsiness, nasal stuffiness, nausea, weight gain, and diarrhea. Less frequent complications of deserpidine therapy are aggravation of peptic ulcer, epistaxis, and skin eruption. Alcohol, barbiturates or narcotics may potentiate action of deserpidine.

# EUTONYL®
PARGYLINE HYDROCHLORIDE

# EUTRON™
Each tablet contains Pargyline Hydrochloride 25 mg.
with Methyclothiazide 5 mg.

*Indications:* For treatment of patients with moderate to severe hypertension, especially those with severe diastolic hypertension. Not recommended for use in patients with mild or labile hypertension amenable to therapy with sedatives and/or thiazide diuretics alone.

*Contraindications:* Pheochromocytoma, advanced renal disease, paranoid schizophrenia and hyperthyroidism. Until further experience is gained, not recommended for use in patients with malignant hypertension, children under 12, or pregnant patients.

Concomitant use of the following is contraindicated: other monoamine oxidase inhibitors; parenteral forms of reserpine or guanethidine; sympathomimetic drugs; foods high in tyramine such as cheese; imipramine and amitriptyline, or similar antidepressants; methyldopa. Interval of two weeks should separate therapy and use of these agents.

*Warnings:* Pargyline hydrochloride is a monoamine oxidase inhibitor. Warn patients against eating cheese, and using alcohol, proprietary drugs or other medication without the knowledge of the physician. When necessary to administer alcohol, narcotics (meperidine should be avoided), antihistamines, anesthetics, barbiturates, chloral hydrate and other hypnotics, sedatives, tranquilizers, or caffeine, these can be used cautiously at a dosage of ¼ to 1/5 the usual amount. Adjust dose of anesthetic agents to response of patient. Avoid parenteral administration where possible. Withdraw pargyline two weeks before elective surgery.

Warn patients about the possibility of postural hypotension. Those with angina or other evidence of coronary disease should not increase physical activity. Pargyline may lower blood sugar. Avoid use of enteric-coated potassium tablets, as these may induce serious or fatal small-bowel lesions; if added potassium intake is desired, dietary supplementation is recommended. Coated potassium tablets should be reserved for cautious use when adequate dietary supplementation is impractical.

*Precautions:* Measure blood pressure while patient is standing to determine antihypertensive effect. Use with caution in hyperactive or hyperexcitable persons. Such persons may show increased restlessness and agitation. Withdraw drug during acute febrile illness. Watch patients with impaired renal function for increasing drug effects or elevation of BUN and other evidence of progressive renal failure; withdraw drug if such alterations persist and progress. Use with caution in patients with liver dysfunction or progressive liver disease. As with all new drugs, complete blood counts, urinalyses, and liver function tests should be performed periodically. With prolonged therapy, examine patients for change in color perception, visual fields, and fundi.

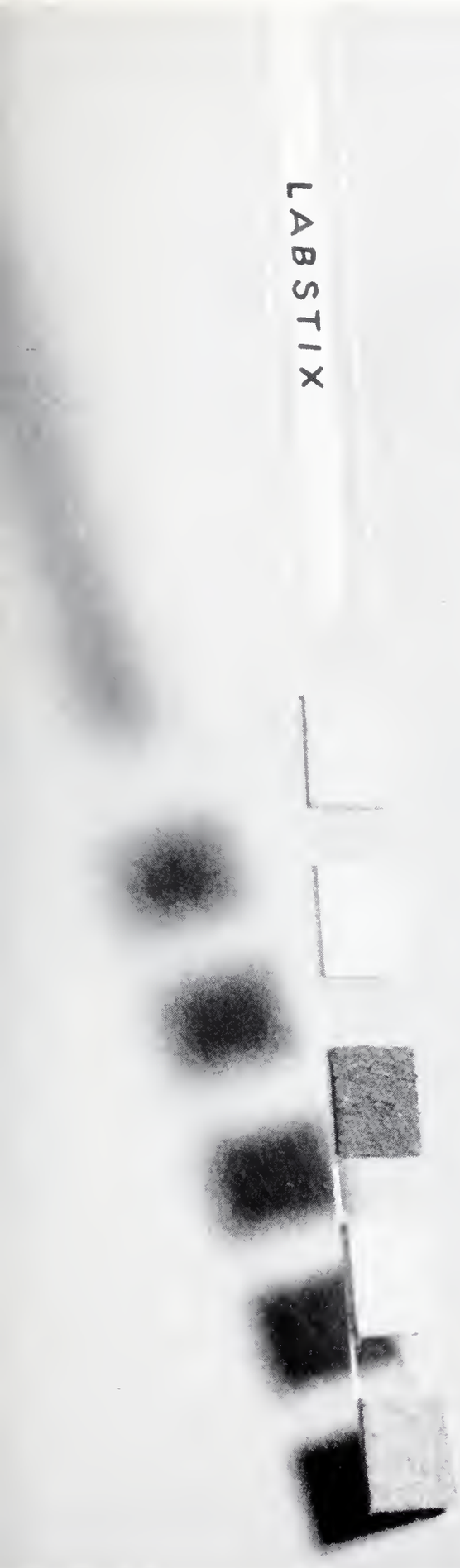
During intensive or prolonged methyclothiazide therapy, watch chloride and potassium levels (especially latter if patient is on digitalis). Methyclothiazide also may reduce arterial response to pressor amines. Use thiazides with caution in pregnancy (bone marrow depression, thrombocytopenia, or altered carbohydrate metabolism are possible in certain newborns). Thiazide drugs may increase responsiveness to tubocurarine.

*Side Effects:* Pargyline may be associated with orthostatic hypotension. Mild constipation, slight edema, dry mouth, sweating, increased appetite, arthralgia, nausea and vomiting, headache, insomnia, difficulty in micturition, nightmares, impotence, delayed ejaculation, rash, and purpura have been encountered with pargyline. Hyperexcitability, increased neuromuscular activity (muscle twitching) and other extra-pyramidal symptoms have been reported. Drug fever is extremely rare. Congestive heart failure has been reported in a few patients with reduced cardiac reserve.

Thiazide side effects also include blood dyscrasias, elevation of BUN, serum uric acid, or blood sugar, electrolyte imbalance, g.i. disturbances, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice, pancreatitis, and gout. Nocturia has been observed with the combination.

704075

ABBOTT




# new from Ames
# 5 basic uro-analytical facts in 30 seconds

# Labstix®

BRAND REAGENT STRIPS

**...broadest urine screening possible from a single reagent strip**

Urine test results with LABSTIX Reagent Strips can represent significant guides to differential diagnosis or therapy in many conditions. An unexpected "positive" may enable you to detect hidden pathology—long before more recognizable symptoms become evident. Negative results, which permit you to rule out abnormalities in a broad clinical range, can serve as baseline values for reference in future examinations. The 5 colorimetric test areas encompassed on LABSTIX Reagent Strips are:

**pH**—values are read numerically in the essential range of pH 5 to pH 9.

**Protein**—results are read either in the "plus" system or in mg. % in amounts approximating "trace," 30, 100, 300, and over 1000 mg. %.

**Glucose**—provides a "Yes-or-No" answer for urine "sugar spill."

**Ketones**—detects ketone bodies in urine—**both** acetoacetic acid and acetone. Reacts with as little as 5 to 10 mg. % of acetoacetic acid.

**Occult Blood**—specific test for intact red cells, hemoglobin or myoglobin. Results are read as negative, small, moderate or large amounts.

**Now a Clear Reagent Strip of Firm Construction**

**...facilitates handling during testing procedure. Excellent color contrast made possible by the clear plastic strip, together with the clearly defined color charts provided, permits precise, reproducible colorimetric readings in all 5 test areas. A more definitive interpretation of uro-analytical facts is made possible.**

Available: LABSTIX Reagent Strips, bottles of 100 (color charts are supplied with each bottle). 179R66

Ames Company
Division Miles Laboratories, Inc.
Elkhart, Indiana, U.S.A.

Ames

announcing
important dosag
reduction

**new**

# Nor

(norethindrone 1mg. c̄ mestranol 0.05mg

lower cost
to patients




norethindrone — an original steroid from

SYNTEX

LABORATORIES INC., PALO ALTO, CALIF.

rescribing information available from your pharmacist or Syntex representative.

## *Hawaii Medical Association* *continued from 344*

*School Health:* The Council was asked to make an expression relative to the proposal that there be an Administrative Medical Department within the Department of Education.

**ACTION:**

**It was voted that the School Health Committee make this recommendation to the Department of Education.**

*Disaster:* The Council was advised that the President signed the protocol agreement for the State of Hawaii.

**ACTION:**

**It was voted to approve this agreement.**

*TV-Radio:* Funds are requested for the purchase of four video tapes, an x-ray view box, and an increase in Gordon Burke's salary.

**ACTION:**

**It was voted that Gordon Burke's salary be increased to $30 per program retroactive to the January 4 program.**

**It was voted that the TV-Radio Committee be allotted $500 for the four video tapes.**

It was noted that Dr. Tomita will donate one x-ray view box to the TV-Radio Committee.

**ACTION:**

**It was voted to commend the President for his graciousness.**

*Committee Reports Not Acted Upon:* All reports were filed.

*continued page 352*




Tandearil®
oxyphenbutazone

*Therapeutic Effects:* Tandearil is a nonhormonal compound which may rapidly resolve inflammation and help restore normal joint function. Its action does not affect pituitary-adrenal function or impair immune responses. Its value in osteoarthritis is especially noteworthy because this disorder responds inconsistently to steroids and is often resistant to salicylates. Further, indomethacin is limited only to osteoarthritis of the hip, whereas oxyphenbutazone is effective in all forms of the disease.

*Contraindications:* Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently.

*Warning:* If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with great caution in the first trimester of pregnancy.

*Precautions:* Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patient should be closely supervised and should be warned to report immediately fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools or other evidence of intestinal hemorrhage. Make regular blood counts. Discontinue the drug and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

*Adverse Reactions:* The most common are nausea, edema and drug rash. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. Infrequently, agranulocytosis, or a generalized allergic reaction may occur and require withdrawal of medication. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported but cannot definitely be attributed to the drug. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

*Dosage in Osteoarthritis:* The initial daily dosage in adults is 300-600 mg. in divided daily doses. When improvement occurs, dosage should be decreased to the minimum effective level; this should not exceed 400 mg. daily, and is often achieved with only 100-200 mg. daily.

For complete details, please refer to full prescribing information. 6562-VI(B)R

*Availability:* Tablets of 100 mg.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York

Geigy

# Tandearil®
oxyphenbutazone

# helps osteoarthritic joints move again



3 out of 4 osteoarthritics completely or markedly improved

| | |
|---|---|
| Sperling, I L.: 3 Years' Experience with Oxyphenbutazone in the Treatment of Rheumatic Disorders, Applied Therapeutics 6:117, 1964. | 76.9% of 407 patients |
| Watts, T W , Jr.: Treatment of Rheumatoid Disorders with Oxyphenbutazone, Clin. Med. 73:65, 1966. | 84.6% of 39 patients |

Please see adjoining page for brief prescribing summary

TA-4919 PC


How long will it take him
to recover from the flu
if he just doesn't care?

**Does he really care? Is he alert, encouraged, positive and optimistic about getting out of bed and back to work soon? Or is he giving in to the depressing impact of confinement? When functional fatigue complicates convalescence, Alertonic can help...**

Pleasant-tasting Alertonic is pipradrol hydrochloride—an effective cerebral stimulant whose gentle analeptic action helps counteract the apathy and inertia that so often delay convalescence—together with an excellent vitamin and mineral formula, in a satisfying 15% alcohol vehicle.

Nothing fosters confidence and a sense of well-being better than your own personal warmth, understanding and encouragement together with Alertonic to help insure prompt response.

*Adequate dosage is important: Prescribe Alertonic—one tablespoonful t.i.d., 30 minutes before meals...tastes best chilled.*

*And for your patient's sake, prescribe Alertonic in the convenient, economical one-pint bottle.*

# Alertonic®

*Available Only On Prescription*

Each 45 cc. (3 tablespoonfuls) contains: alcohol, 15%; pipradrol hydrochloride, 2 mg.; thiamine hydrochloride (vitamin $B_1$) (10 MDR*), 10 mg.; riboflavin (vitamin $B_2$) (4 MDR), 5 mg.; pyridoxine hydrochloride (vitamin $B_6$), 1 mg.; niacinamide (5 MDR), 50 mg.; choline,† 100 mg.; inositol,† 100 mg.; calcium glycerophosphate, 100 mg. (supplies 2% MDR for calcium and for phosphorus) and 1 mg. each of the following: cobalt (as chloride), manganese (as sulfate), magnesium (as acetate), zinc (as acetate), and molybdenum (as ammonium molybdate).

*Multiple of adult Minimum Daily Requirement supplied.
†The need for these substances in human nutrition has not been established.

***Indications:*** 1. Functional fatigue such as that often associated with: a depressing life experience or stressful time of life; advancing years; convalescence; limited activity or confinement. 2. Poor appetite and vitamin-mineral deficiency as they occur in: patients having faulty eating habits; geriatric patients who are losing interest in food; patients convalescing from debilitating illness or surgery.

***Contraindications:*** As with other drugs with CNS stimulating action, Alertonic is contraindicated in hyperactive, agitated or severely anxious patients and in chorea or obsessive compulsive states.

***Side effects:*** Reports of overstimulation have been rare. Patients who are known to be unduly sensitive to the effects of stimulant drugs should be observed carefully in the initial stages of treatment.

***Dosage:*** Adults, 1 tablespoonful; children (over 15 years old), 1 to 2 teaspoonfuls; children (4 to 15 years old), 1 teaspoonful. To be taken three times daily 30 minutes before meals.

Merrell

THE WM. S. MERRELL COMPANY
Division of Richardson-Merrell Inc.
Cincinnati, Ohio 45215

6-7907

## *Hawaii Medical Association* *continued from 348*

**NEW BUSINESS**

*Legal Comsel:* Funds are requested for transportation and expenses for the legal counsel.

**ACTION:** *

**It was voted that funds for legal counsel to attend the March 9-11 National Medicolegal Symposium in Miami be allocated.**

*Funds for Sending Staff Member to School for New Medical Executives:* There was discussion about sending Mr. Patrick Godfrey to the school for new medical executives in Chicago which will be held for one week, March 13-17.

**ACTION:**

**It was voted to approve funds for Mr. Godfrey to attend this school in Chicago for one week.**

*HAMPAC Board:* The President advised that the present Board was illegally constituted and that he would circulate by mail his proposal for a new Board for Council approval.†

**ADJOURNMENT**

The meeting adjourned at 12:45 A.M.

* Counsel subsequently indicated subject matter of the meeting would not further the HMA's purposes and did not attend.

† The following HAMPAC Board members were subsequently approved: Robert M. Miyamoto, William E. Iaconetti, Don E. Poulson, Rodman B. Miller, L. Q. Pang, Herbert Y. H. Chinn, P. H. Liljestrand, George Goto, B. A. Richardson, Yonemichi Miyashiro, Mrs. Robert Jay, Mrs. Eldon Dykes.

## *Notes and News* *continued from 327*

*Tennis:* The "Sunrisers" (a group of physicians addicted to 7:00 a.m. Sunday tennis) completed their recent doubles series. The winning duo of **Ben Tom** and **Hunky Chun** proved too formidable for their opponents.

### Health Department

We had missed this tidbit about eight Hansen's Disease patients who were caught playing poker at the Hale Mohalu treatment center. When the obtrusive administrator failed to break up the game, he summoned the police. **Ira Hirschy,** chief of the Hansen's Disease Branch, investigated and made the following remarks: "At first it looked as if they were gambling. It turned out later they were using chips for counters, to see who was winning and losing. In other words, it looked like what it wasn't." Being a penny ante player ourself, we wonder what the fuss was about.

We would like to add this excerpt from a testimonial to **Leo Bernstein** who retired in December: "Dr. Bernstein's innate modesty has kept him out of the public spotlight. His associates, however, are impressed by his zeal, his grasp of a wide range of health programs and problems, his adherence to high ethical standards, and his leavening sense of humor. Dr. Bernstein is representative of a large number of public servants who belie the often ill-conceived image of public bureaucracy. His quiet devotion to the public welfare and the firm loyalty of his associates mark him as a man whose services will be missed." We heartily agree.

We also congratulate **Walter Quisenberry,** new State Director of Health, for his unselfish stand on the Public Health Fund of the Honolulu Chamber of Commerce. When it was suggested that the functions of the Public Health Committee be turned over with the fund to his wide domain, he prudently declined.

*continued page 355*




These glasses are important to him—in his work, socially, and in terms of his physical well-being.

When's the last time you had an eye check? Schedule an appointment soon with your eye physician.

OBRIG Contact Lenses fitted by prescription. We are GUILD OPTICIANS, serving Hawaii since 1939.

OPTICAL DISPENSERS
of Hawaii, Inc.

1133 BISHOP ST. 576-570
312 ALA MOANA BLDG. 976-925
PROFESSIONAL CENTER BLDG., KAILUA 256-030

Your stationery is a reflection of you... be certain the reflection is good!

*star-bulletin printing company*

*the hallmark of fine printing in honolulu*




# Phenaphen® with Codeine

the only leading compound analgesic that calms instead of caffeinates

*Each capsule contains:*

Phenobarbital (¼ gr.) ..... 16.2 mg.
*(Warning: may be habit forming)*
Aspirin (2½ gr.) .....162.0 mg.
Phenacetin (3 gr.) .....194.0 mg.
Hyoscyamine sulfate.....0.031 mg.
Codeine phosphate.....¼ gr. (No. 2),
½ gr. (No. 3), 1 gr. (No. 4)
*(Warning: may be habit forming)*

*Contraindications:* Hypersensitivity to any ingredient.

*Precautions:* As with all phenacetin-containing products, avoid excessive or prolonged use.

*Side Effects:* Side effects are uncommon—nausea, constipation, and drowsiness have been reported.

A-H-ROBINS

A. H. ROBINS CO., INC., Richmond, Va. 23220

# THREE TIMES A YEAR

*Your patients without a plan to economically protect them when they are in need of medical assistance may join Hawaii's own community service medical plan on an individual basis three times a year.*

*Membership is open to qualified individuals of all ages in*

MARCH — JULY — *and* — NOVEMBER

*HMSA is a non-profit, community service organization. As such it is able to provide tremendous benefits for reasonably low dues.*

*HMSA is the medical plan which gives you free choice of doctors and hospitals — an extremely desirable feature.*

Member of Western Conference of Prepaid Medical Service Plans

HMSA

® BLUE SHIELD PLAN FOR HAWAII

## HAWAII MEDICAL SERVICE ASSOCIATION

*For More than 28 Years — Hawaii's Own / Hawaii Owned*

## *Notes and News* *continued from 352*

**Louise Childs,** chief of the Maternal and Child Health Branch and a practicing pediatrician until two years ago, gave practical hints for a healthier Halloween. She remembered that doctors have a bumper crop of stubbed and cut toes and puncture wounds to treat the morning after, and recommended that children wear shoes and slippers to go trick-or-treating. She also recommended the use of flashlights rather than candles, the use of reflectorized tape and arm bands in the costumes, the avoidance of paper costumes and flammable wigs and whiskers, and the banning of masks that block vision. Lot of good ole savvy, that gal.

## Members Speak Up

The "Hearts and Husbands" program by the Hawaii Heart Association on February 1 was a heartening success. **David Lee Pang** warned that "unknowingly, many a young bride sets out to kill her husband. They provide them with delectable dishes to prove how much better off their new husbands are than in their bachelor days." He suggested that to reduce cholesterol, the meat diet should be "things that fly or swim and not animals that walk." **Morton Berk,** who is admittedly a fanatical anti-smoker, spoke on "Facts in the Cigarette Case." **Ed Furukawa,** who had a coronary attack himself last year, spoke from experience on the effect daily strains and tense emotions have on the heart. **Dick Blaisdell** discussed "Effects of Race and Heredity on Cardiovascular Disease" and pointed out that people of Hawaiian ancestry are three times more likely to suffer a fatal heart attack than people of Japanese ancestry. **Ed Chesne,** who spoke on "Daignosis of Heart Disease," was asked, "Does an overactive sex life have any effect on the incidence of heart disease?" Pegi Scully, who fielded the question, "turned a nice Valentine pink," "Well," answered Ed suavely, "who's to say what's overactive?" and hedged with "what I usually say is, 'if it does, who cares?' "

The exploits of **Nobu Nakasone** in love and golf are already legend and now he has added music to his repertoire. While conductor George Barati's future with the local symphony was being debated in January, Nobu circulated a letter to the directors which has the overtones of a physician's kindness and frankness: "We are grateful to Mr. Barati for what he has been able to do with our orchestra up to a point. But . . . he has never, and will never lift our orchestra to the full potential of their skills to the level our guest conductors have shown us" because he "does not measure up in talent and greatness to the job our orchestra now requires for its future greatness." Nobu wrote that "in attaining the highest peaks of musical experience . . . it is axiomatic . . . that there be a conductor of the first rank who can inspire the orchestra to these heights with the spark and fervor of his genius. . . ." (We discovered that his musical taste is no humbug for in his exquisite new home set in the Dowsett highlands, he has a stereo set which stretches across the room and can bring the world's name symphony orchestras right into his living room in their full tone orchestration. . . .) A vain attempt at repartee by pro-Barati Robert Loveless, who also circulated a letter to the 75-member board of directors, could not measure up to Nobu's critique.

## Requiem

In **Bob Ho,** we shall sorely miss a dear friend, a neighbor, a community and medical leader, and above all a dedicated physician and father. We learned that at the

*continued page 359*


*When the problem is only skin deep*

**USE 'POLYSPORIN'® brand POLYMYXIN B-BACITRACIN OINTMENT**

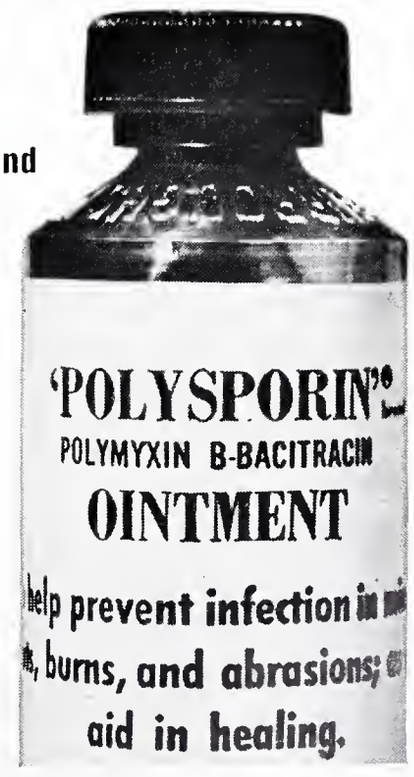
**for topical antibiotic therapy with minimum risk of sensitization**

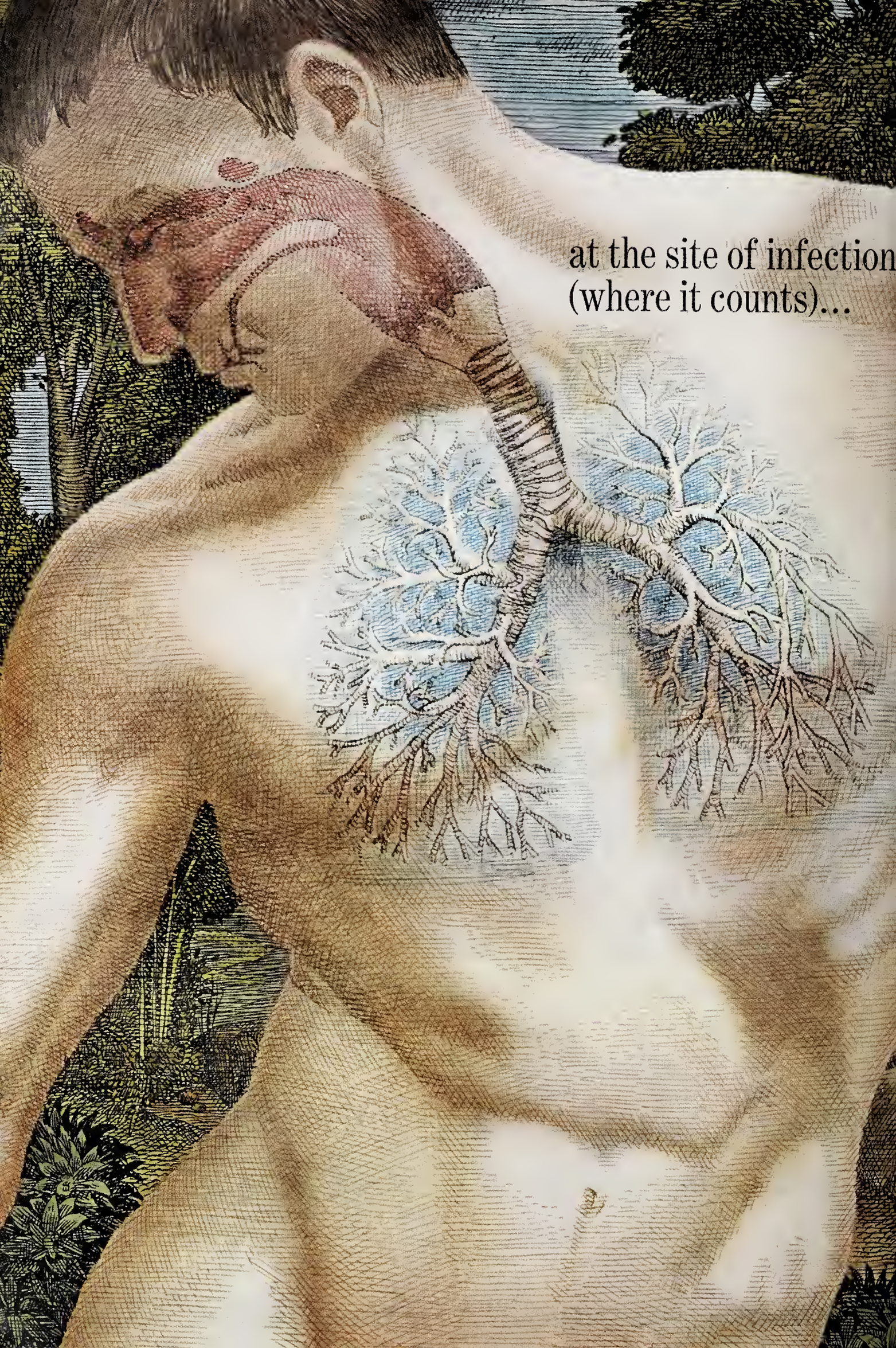
Caution: As with other antibiotic products, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

Supplied in ½ oz. and 1 oz. tubes.

Complete literature available on request from Professional Services Dept. PML.

BURROUGHS WELLCOME & CO. (U.S.A.) INC.
Tuckahoe, N.Y.




at the site of infection
(where it counts)...

# Ilosone® provides more antibacterial activity than any other oral erythromycin

**Acid stable, better absorbed ... Ilosone produces faster, higher, more prolonged blood levels, even in the presence of food**[1-3]

Because it is the most active form of oral erythromycin, Ilosone can help assure consistently greater antibacterial activity at the site of infection. Ilosone produces peak antibacterial blood levels two to four times those of other erythromycin preparations.[1,2] Not only are these levels attained earlier, but they are maintained for much longer periods. Even the presence of food does not seem to affect the activity of Ilosone.[1,3]

In the treatment of patients with bacterial infections susceptible to erythromycin, Ilosone has compiled an excellent therapeutic record. Since it exerts its greatest activity against gram-positive organisms, it is particularly useful in common respiratory and soft-tissue bacterial infections. Ilosone kills—not merely inhibits—streptococci, pneumococci, and more strains of staphylococci than any other macrolide antibiotic. This bactericidal action, coupled with the high antibacterial levels attained, makes Ilosone especially valuable in patients with low host resistance, such as infants, debilitated individuals, and diabetics.

Ilosone has shown no cross-resistance with penicillin and may be effective against organisms that have become resistant to that agent. Despite its high antibacterial activity, Ilosone has demonstrated a low incidence of side reactions. Blood dyscrasias, ototoxicity, and tooth staining have not been observed. Infrequent cases of drug idiosyncrasy, manifested by a cholestatic jaundice, have occurred, but there have been no known definite residual effects.

700121

Ilosone®

Lilly

Erythromycin Estolate

*(See next page for prescribing information.)*

# Ilosone® the most active oral form of erythromycin

**Description:** Ilosone is the most active form of oral erythromycin that has been developed. Because it is stable in acid, well absorbed, and excreted in lesser amounts in the bile, it provides faster, higher, and longer-lasting levels of antibacterial activity (ABA) in the serum, even when taken with food, than do comparable doses of erythromycin.

**Indications:** Ilosone is indicated in infections caused by microorganisms sensitive to its action (especially staphylococci, hemolytic streptococci, and pneumococci). The drug is therefore useful in a high proportion of bacterial diseases encountered in clinical practice and particularly in the treatment of bacterial infections of the upper and lower respiratory tract and soft tissues.

In the treatment of acute bacterial pharyngitis and tonsillitis, this antibiotic has promptly eradicated the bacteria (streptococci) and has produced a parallel prompt clinical improvement. There have been no group A beta-hemolytic streptococci resistant to this preparation. In beta-hemolytic streptococcus infections, treatment should be maintained for ten days to prevent the development of rheumatic fever or glomerulonephritis.

Erythromycin estolate has proved to be very effective in pneumococcus pneumonia and in acute bronchitis with pneumococci on culture. Bronchopneumonia and otitis media in children have responded well to its use.

The antibiotic has been used very successfully in staphylococcus infections. Good therapeutic results have been obtained in soft-tissue infections, abscesses, cellulitis, carbuncles, wound infections, and furunculosis.

In serious staphylococcus infections, erythromycin preparations should be used only in combination therapy with other antimicrobial agents. As is the case with any treatment regimen used in these severe conditions, surgical procedures should be performed when indicated, and large dosages of the antimicrobial agents should be employed. In this fashion, Ilosone has been effective in staphylococcus pneumonia, osteomyelitis, septicemia, empyema, and meningitis.

Multiple 500-mg. doses of the drug have been useful in gonorrhea and syphilis. Since penicillin is the drug of choice for the treatment of syphilis and gonorrhea, erythromycin estolate should be employed for these infections only in patients with a history of penicillin allergy. Also, other infections due to susceptible bacteria in patients known to be hypersensitive to penicillin or other antibiotics may be considered for treatment with Ilosone.

**Contraindications: Ilosone is contraindicated in patients with a known history of sensitivity to this drug and in those with preexisting liver disease or dysfunction.**

**Side-Effects:** Data obtained from seven years' use of propionyl erythromycin ester and erythromycin estolate (Ilosone) indicate that hepatic dysfunction with or without clinical jaundice may occur during or following courses of therapy with the drug.

Changes in liver function tests in such cases have been indicative of intrahepatic cholestasis. The symptoms appear to be the result of a form of sensitization. The initial symptoms have appeared in some cases after a few days of treatment but generally have followed one or two weeks of continuous therapy or several courses of the drug. Symptoms reappear promptly if the drug is readministered to sensitive patients, usually within forty-eight hours. Eosinophilia was noted in peripheral blood counts. The findings readily subsided without apparent residual effects when treatment was discontinued. Recovery was delayed in one reported instance. The physician indicated in this case that either drug-induced jaundice or viral hepatitis may have been responsible for the findings.

In one clinical study involving ninety-three patients treated with the antibiotic, three cases of jaundice were observed and an additional eleven cases developed some changes in liver function tests. Three of the patients had abnormal liver function tests a second time on readministration of the drug.

Even though it is assumed that not all cases of jaundice have been reported, it seems clear that the number is small compared with the amount of drug that has been used. Reported cases have included persons in whom there had been administered other drugs known to be associated at times with hepatic side-effects and cases in which the presence of viral hepatitis or other disease may have been responsible for the findings. In some of the cases, associated gastro-intestinal symptoms simulated the colic of biliary tract disease. In other instances, clinical symptoms and results of liver function tests resembled findings in extrahepatic obstructive jaundice. It appears that the occurrence of jaundice after administration of Ilosone is infrequent, but further investigations are being made to estimate its incidence more accurately.

In those cases mentioned above in which jaundice appeared to be definitely related to use of the drug, laboratory findings characterized by increased direct-reacting bilirubin, ele alkaline phosphatase levels, negative or weakly positive cep flocculation and thymol turbidity tests, elevated serum glu oxalacetic transaminase levels, peripheral eosinophilia, and mal cholecystograms.

Individual idiosyncrasy seems evident since jaundice ha been reported in other patients taking prolonged courses o medication. Patients with chronic infection have been give to 2 Gm. of the drug daily for periods of two to six months patients with rheumatic fever have taken prophylactic dos 0.5 Gm. daily for two years without difficulty. In one gro 144 patients who received the drug daily for two years, no j dice was noted. It was of interest that members of six of patients' families, who were not taking the drug, had epi of jaundice during the study period.

Transaminase and serum alkaline phosphatase levels determined in a group of fifty-four adults and children who 250 mg. of Ilosone daily for an average of sixteen month rheumatic fever prophylaxis. The results were compared those of a similar group of forty-four patients who received icillin. There were no cases of jaundice in either group. Eleva of SGPT and serum alkaline phosphatase levels during the co of treatment was observed in one patient treated with Ilo and in two patients treated with penicillin. Seven other pati in the group receiving Ilosone and four others in the penic group showed elevations in one of the tests at some time du administration of the drugs.

Very satisfactory therapeutic results, without toxicity, reported in 102 pediatric patients who received short-term ( day) courses of Ilosone in the treatment of streptococcus in tions. Results of liver function tests in these patients were c parable to those in a similar control group who had rece penicillin.

Gastro-intestinal disturbances not associated with hepatic fects are observed in a small proportion of individuals as a re of a local stimulating effect of the medication on the aliment tract; however, the normal intestinal gram-negative bacte flora is not appreciably altered by erythromycin drugs.

Although allergic manifestations are uncommon with the of erythromycin, there have been occasional reports of urtica skin eruptions, and, on rare occasions, anaphylaxis.

**Administration and Dosage:** Ilosone is administered orally.

Ilosone Pulvules®
Ilosone Chewable Tablets
Ilosone Drops
Ilosone, 125, for Oral Suspension

For infants and for children under twenty-five pounds of b weight, the usual dosage is 5 mg. per pound every six hours; children twenty-five to fifty pounds, 125 mg. every six ho (Tablets Ilosone Chewable should be chewed or crushed swallowed with water.)

For adults and for children over fifty pounds, the usual dos of Ilosone is 250 mg. every six hours.

For severe infections, these dosages may be doubled.

When larger doses are indicated, parenteral erythromy therapy should be considered.

In the treatment of syphilis, the recommended total dosag 20 to 30 Gm. given in divided doses for a period of ten to fift days. Close follow-up of the patient is necessary since eryth mycin drugs have not had adequate evaluation in all stages syphilis. Examinations of spinal fluid are recommended as p of the follow-up therapy.

For gonorrhea, 500 mg. four times a day for four days recommended. In the treatment of gonorrhea, patients with suspected lesion of syphilis should have a dark-field examinati before receiving antibiotics, and monthly serologic tests sho be made for a period of three months.

**How Supplied:** Pulvules Ilosone, Capsules, N.F., 125 and 250 m (equivalent to base), in bottles of 24 and 100.

Tablets Ilosone Chewable, N.F., 125 mg. (equivalent to base in bottles of 50.

Ilosone Drops, 5 mg. (equivalent to base) per drop, in 10-c size packages, with dropper calibrated at 25 and 50 mg.

Ilosone, 125, for Oral Suspension, N.F., 125 mg. (equivale to base) per 5-cc. teaspoonful, in 60 and 150-cc.-size package

*References:* 1. Griffith, R. S., and Black, H. R.: Am. J. M. Sc., *247*:69, 19
2. Griffith, R. S., and Black, H. R.: Antibiotics & Chemother., *12*:398, 19
3. Hirsch, H. A., Pryles, C. V., and Finland, M.: Am. J. M. Sc., *239*:198, 1960.

*Additional information available to physicians upon request.*
*Eli Lilly and Company, Indianapolis, Indiana 46206.*

Lilly

St. Francis Hospital ICU where he had a cardiac arrest immediately upon arrival, the colleagues normally conditioned to being unemotional in emergencies, worked frantically and teary eyed for hours to resuscitate him. We feel that Bob literally sacrificed his life for his colleagues, his patients, and his family by his complete dedication to medicine and community and that we owe him a debt which we can repay only in small measure by comforting his surviving family and continuing his dedication to life. The following excerpts from attorney William Chee's eulogy best echo our sentiments: "We are saddened by the untimely death of Robert P. C. Ho. But in our sorrow, we find comfort in remembering him as he lived . . . for although his life was short, his blessings were many. His achievements, accomplishments, and successes were that of a man who lived a full and complete life. I knew him as an able and learned person, yet truly modest . . . who was confident of himself, yet very humble . . . who was busy, yet gave generously of his time to his friends, his fellow doctors, and to the hospital he loved. I knew Bob as a perfectionist, always wanting to do his best, no matter what the endeavor. . . . He was one who took a position on issues and fought for what he believed in, yet he was a pleasant person to work with, even if you differed with him. I knew Bob as a serious person, but one with a delightful sense of humor. I knew Bob as a loyal and sincere friend, who always had a friendly smile and a kind word . . . one you can depend upon in your hour of need, and who would go out of his way to help if he can. I knew Bob as a happy family man, a loving husband, a good father . . . kind and considerate, and proud, in his quiet way, of his beloved wife and his five wonderful children. I knew Bob as a dedicated doctor who responded promptly to every emergency, regardless of the hour of day or night . . . to every call, regardless of the nature of the ailment. I knew him as a doctor who was genuinely understanding and sincerely sympathetic with the anxieties and fears of his patients . . . a doctor who spent many hours counselling and comforting patients whose bodies were not ill, but who were afraid and anxious, or who were in sorrow."

"Bob was a very warm and kind person who, because of his goodness, touched the lives of many people who came in contact with him. . . . Bob's presence will be sorely missed by all of us. . . . But the memory of him and the way he lived during his lifetime will be with us always."

For the past year, we missed the familiar figure, impeccably dressed, inevitably capped, strolling down Keeaumoku Street with cane in hand. We wondered and hoped. Then we learned that **Dr. Ichitaro Katsuki,** the grand old man of Hawaii medicine, had peacefully died on January 18 at the truly venerable age of 101. Bob Katsuki told us how his dad's legs had started to fail along with sight and hearing, but that he had remained mentally alert to the very end. Since his late 90's, the elder Katsuki walked ten blocks daily after a lunch in Waikiki and on reaching home, read before and after supper to 9 or 10 P.M. He felt that he couldn't converse with his physician sons, David, Robert, and Sanford, without reading scientific and medical works, and maintained that "mental activity is just as important as physical activity." At age 99, he expressed his personal philosophy on longevity: "Moderation is the answer. Excesses in everything are bad, such as women and love affairs." He had been a three-pack-a-day smoker until 1920 when he quit smoking.

In the light of the object lessons from Bob Ho's premature death and the elder Katsuki's longevity, we as physicians need to pause and reflect on the oft quoted and unheeded saying, "Physician, heal thyself." We feel certain that Bob Ho would have wanted us to. ■




THE ONLY QUESTION THIS YEAR IS: WHICH CADILLAC?

*See all the exciting new Cadillac models at* **SCHUMAN'S**

*1234 South Beretania Street*

# Diagnosis:

## cystitis

usually
gram-negative*

a hazard of
instrumentation

# Therapy:

# NegGram®

Brand of

## nalidixic acid

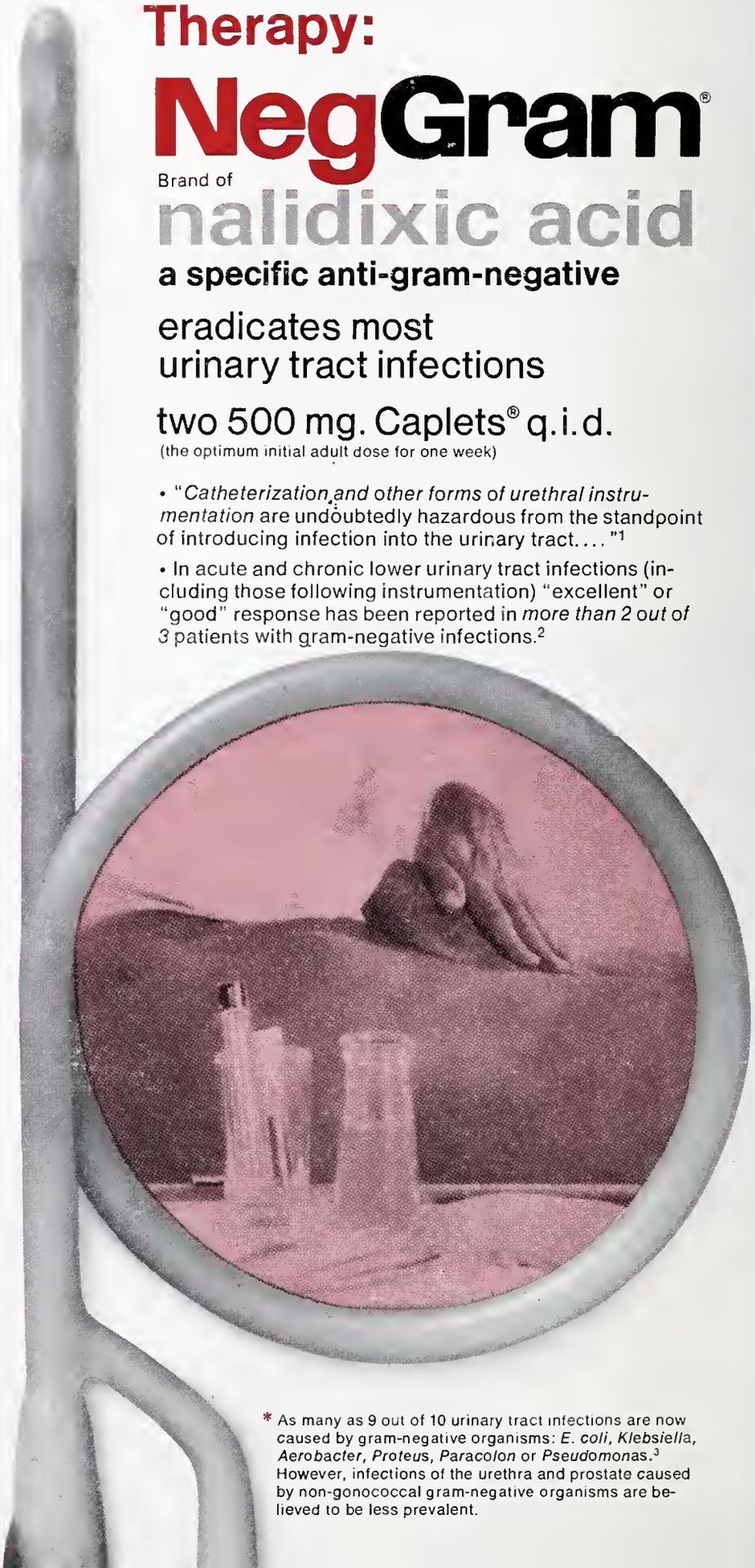
**a specific anti-gram-negative**

eradicates most
urinary tract infections

two 500 mg. Caplets® q.i.d.
(the optimum initial adult dose for one week)

• "*Catheterization and other forms of urethral instrumentation* are undoubtedly hazardous from the standpoint of introducing infection into the urinary tract. . . ."[1]

• In acute and chronic lower urinary tract infections (including those following instrumentation) "excellent" or "good" response has been reported in *more than 2 out of 3* patients with gram-negative infections.[2]



**Indications:** Urinary tract infections caused by gram-negative and some gram-positive organisms.

**Side effects:** Mainly mild nausea, vomiting, and other gastrointestinal disturbances; in occasional instances, drowsiness, weakness, pruritus, rash, urticaria, mild eosinophilia, reversible subjective visual disturbances (overbrightness of lights, change in visual color perception, difficulty in focusing, decrease in visual acuity and double vision), and reversible photosensitivity reactions. Marked overdosage, usually coupled with certain predisposing factors, has produced brief convulsions in a few patients.

**Precautions:** As with all new drugs, blood and liver function tests are advisable during treatment longer than 1 or 2 weeks. **Pending further experience, like most chemotherapeutic agents, this drug should not be given in the first trimester of pregnancy. It must be used cautiously in patients with liver disease or severe impairment of kidney function.** Because photosensitivity reactions have occurred in a small number of cases, patients should be cautioned to avoid unnecessary exposure to direct sunlight while receiving NegGram, and if a reaction occurs, therapy should be discontinued. The dosage recommended for adults and children should not arbitrarily be doubled unless under the careful supervision of a physician. Bacterial resistance may develop.

When testing the urine for glucose in patients receiving NegGram, Clinistix® Reagent Strips or Tes-Tape® should be used since other reagents give a false-positive reaction.

**Dosage: Adults: Four Gm. daily by mouth (2 Caplets® of 500 mg. four times daily) for one to two weeks. Thereafter, if prolonged treatment is indicated, the dosage may be reduced to two Gm. daily. Children may be given approximately *25 mg. per pound* of body weight per day, administered in divided doses. The dosage recommended above for adults and children should not arbitrarily be doubled unless under the careful supervision of a physician. Until further experience is gained, infants under 1 month should not be treated with the drug.**

**How supplied:** Buff-colored, scored Caplets of **500 mg. for adults,** conveniently available in bottles of 56 (sufficient for one full week of therapy) and in bottles of 1000. **250 mg. for children,** available in bottles of 56 and 1000.

**References:** (1) Beeson, P. B. (Yale Univ. School of Med.): Enteric bacterial infections (including urinary tract infections), in Beeson, P. B., and McDermott, W.: Cecil-Loeb Textbook of Medicine, 11th ed., W. B. Saunders Company, Philadelphia, 1963, pp. 244-245. (2) Based on 23 clinical papers, 1512 cases. Bibliography on request. (3) Bush, I. M., Orkin, L. A., and Winter, J. W. (Beth Israel Med. Ctr., N.Y.C.): Twelve-year study of urinary bacterial cultures in a total in-patient hospital population, in Sylvester, J. C.: Antimicrobial Agents and Chemotherapy—1964, Ann Arbor, American Society for Microbiology, 1965, p. 722.

* As many as 9 out of 10 urinary tract infections are now caused by gram-negative organisms: *E. coli, Klebsiella, Aerobacter, Proteus, Paracolon* or *Pseudomonas*.[3] However, infections of the urethra and prostate caused by non-gonococcal gram-negative organisms are believed to be less prevalent.

Winthrop

Winthrop Laboratories, New York, N. Y. 10016

of split-thickness skin graft to develop a phase difference at the oval and round windows. Step-by-step details of the surgical procedure are illustrated by stereoscopic photographs on View-Master reels. The ten stereo reels and a compact viewer are conveniently enclosed in pockets attached to the inner back cover of the atlas. However, the stereo photographs do an injustice to an otherwise excellent book. The surgical fields look more like wax models than real human tissue and the magnifications are too low to adequately illustrate the anatomical and surgical details. Nevertheless, this atlas would serve as a useful reference in the otologist's library. The materials are well organized and the section on histopathology of chronic middle ear and mastoid disease is excellent.

HIDEO OSHIRO, M.D.

## Early Management of Acute Trauma

*Edited by Alan M. Nahum, M.D., 336 pp., $21.00, The C. V. Mosby Company, 1966.*

TIMELY SUBJECT material, an array of capable authors (predominantly from UCLA), and a well-organized table of contents should leave one with a great sense of satisfaction after 336 pages. This is definitely not an emergency room *Merck's Manual*. The sections on Psychiatry and Chemotherapy and Chemoprophylaxis, are detailed and tedious, and unlikely to be called to mind in the E.R. The section on Radiology is much too abbreviated; specific views to demonstrate common injuries are inadequately described.

The sections on Shock, Airway and Ventilation problems, and Chest, Spine, Craniocerebral, and Maxillofacial Injuries are good. The section on Abdominal Injuries is good, except that the illustrative roentgenograms are incorrectly labeled. The Genito-urinary chapter is adequate. The chapter on Conservative Treatment of Fractures is mediocre. Few practical points on early treatment are listed. The Operative Treatment chapter exceeds the limitations of the title of the book. The section on Athletic Injuries is practical. The chapters on Wrist, Ankle, and Ocular injuries are all practical, and well presented.

The highlight of the book, in my opinion, is the excellent chapter on Hand Injuries written by Dr. Joseph Boyes.

FREDERICK B. WARSHAUER, M.D.

## It All Started with Hippocrates

*By Richard Armour, with illustrations by Campbell Grant, 136 pp., $3.95, McGraw-Hill Book Co., 1966.*

THIS SHORT HISTORY of medicine is so concise and so funny that a reader might easily fail to appreciate how authentic it is.

HARRY L. ARNOLD, JR., M.D.

## Lectures in Medical Genetics: A Course for Medical Students

*Edited by David Yi-Yung Hsia, M.D., 241 pp., $8.50, Year Book Medical Publishers, Inc., 1966.*

THIS SMALL BOOK, though rather limited in scope, is an extremely good book in which the basics of medical genetics are adequately covered. Since it is a series of lectures, its readability is rather uneven.

The first section, on morphological genetics deals with the anatomy, histology, and structure of the cell and its components. These chapters will update, the medical practitioner who has not read about cells since the introduction of the electron microscope. There is also an extremely good chapter on chromosomal structure and behavior, and most of the basic language and knowledge about chromosomes is discussed. Here, one can learn about mitosis and meiosis, and receive some insight into the chromosomal abnormalities found in various clinical syndromes.

The next section is on biochemical genetics. This field is expanding so rapidly that this section must, of course, be rather superficial. It includes the chemistry of protein synthesis and the genetic control of protein biosynthesis. As such, it covers the DNA-RNA picture as it stands today, and the so-called genetic code. Since a good deal of biochemistry must be known to understand this material, most older graduates will find this section rather hard going.

The last section of the book deals with clinical genetics. Not many actual clinical syndromes are covered: specific genetic syndromes will have to be explored elsewhere. However, using various samples such as the hemoglobinopathies and phenylketonuria, the problems of clinical genetics and their enzymatic etiological defects are nicely explained.

In summary, then, this is an excellent book in which to learn the language and the basic material that must be used in the field of medical genetics.

SORRELL H. WAXMAN, M.D.

## Mechanisms and Therapy of Cardiac Arrhythmias: The Fourteenth Hahnemann Symposium

*Edited by Leonard S. Dreifus, M.D., William Likoff, M.D., Associate Editor John H. Moyer, M.D., 704 pp., $23.00, Grune & Stratton, 1966.*

THESE PAPERS and discussions bring together in a single volume the views of an imposing list of contributors. The very nature of such a text demands inclusion of widely accepted concepts and individual opinions, basic physiology, and practical therapeutics. This inclusive spectrum of topics makes this volume a valuable addition to the reference material of the medical library and the cardiac laboratory, and to the library of the practicing clinician. The merits of the individual papers are, of course, left to the reader. ■

GEORGE I. NAGAO, M.D.

**WILLIAMS MORTUARY**

*"CHAPEL OF THE CHIMES"*

**1076 S. Beretania St., Phone 52-587** **Ample Parking Adjoining Mortuary**

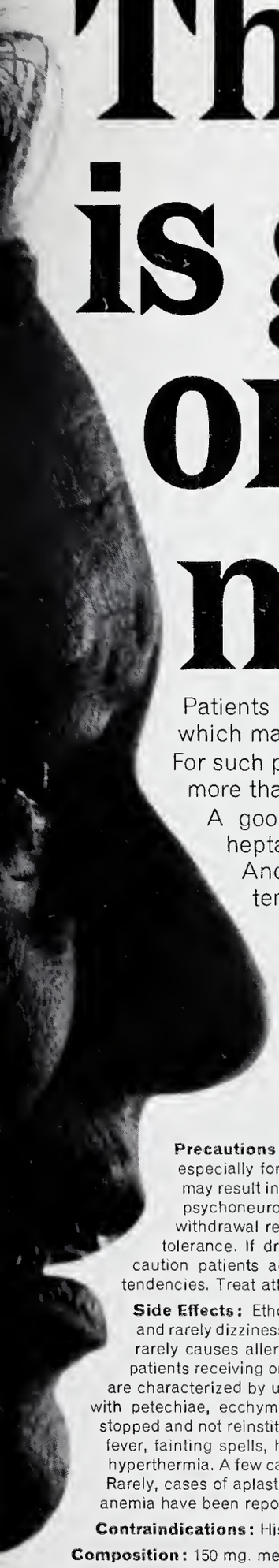
**OVER A CENTURY OF SERVICE**

*"Service measured not by gold but by the Golden Rule"*

***MEMBER***

National Selected Morticians, National Funeral Directors Association,
Order of the Golden Rule, Hawaii Funeral Directors Association





# This pain is getting on my nerves.

Patients in pain often experience concomitant anxiety and tension, which may add to the burden of pain.

For such patients, you may want to prescribe a preparation that offers more than simple analgesia.

A good choice is often EQUAGESIC® (meprobamate and ethoheptazine citrate with aspirin). It helps relieve pain. And anxiety. And skeletal muscle spasm as related to pain or anxiety and tension.

## Equagesic® TABLETS
### (meprobamate and ethoheptazine citrate with aspirin)

Wyeth®

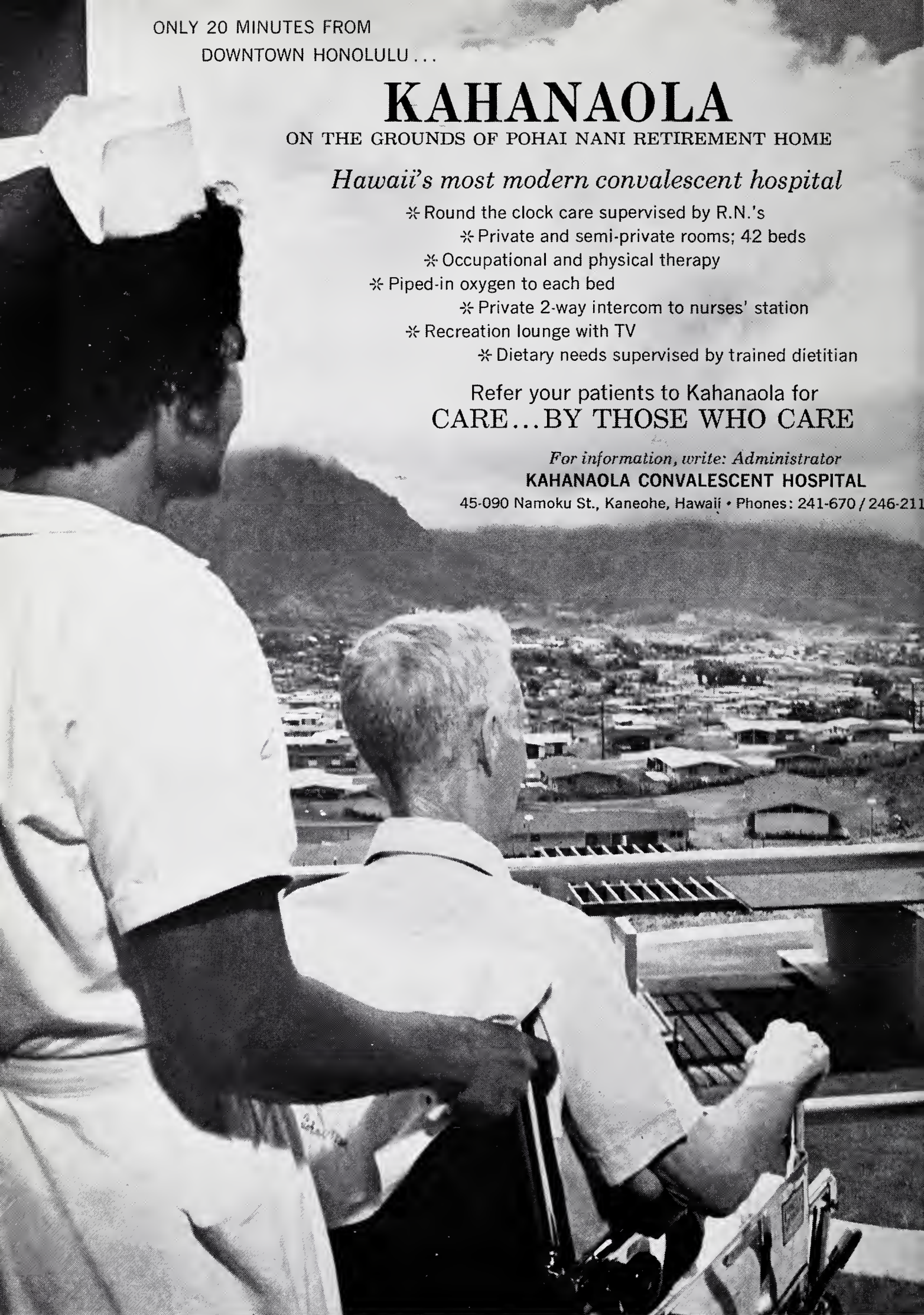
**Precautions:** Keep out of reach of children. Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use of meprobamate may result in dependence or habituation in susceptible persons—as ex-addicts, alcoholics, severe psychoneurotics. Withdraw gradually after prolonged high dosage to avoid possibly severe withdrawal reactions including epileptiform seizures. Warn patients of possible reduced alcohol tolerance. If drowsiness, ataxia or visual disturbances occur, reduce dose. If symptoms persist, caution patients against operating machinery or driving. Give cautiously to patients with suicidal tendencies. Treat attempted suicide with immediate gastric lavage and appropriate supportive therapy.

**Side Effects:** Ethoheptazine and aspirin may occasionally cause nausea, vomiting, epigastric distress, and rarely dizziness and CNS depression. Overdosage may result in salicylate intoxication. Meprobamate rarely causes allergic or idiosyncratic reactions. These reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Mild reactions are characterized by urticarial or erythematous maculopapular rash. Acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever have been reported. Meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioedema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. A few cases of leukopenia, usually transient, have been reported following prolonged dosage. Rarely, cases of aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia have been reported; almost always, in the presence of known toxic agents.

**Contraindications:** History of sensitivity or severe intolerance to aspirin or meprobamate.

**Composition:** 150 mg. meprobamate, 75 mg. ethoheptazine citrate and 250 mg. aspirin per tablet.

Wyeth Laboratories Philadelphia, Pa.



ONLY 20 MINUTES FROM
DOWNTOWN HONOLULU . . .

# KAHANAOLA

ON THE GROUNDS OF POHAI NANI RETIREMENT HOME

*Hawaii's most modern convalescent hospital*

- ✲ Round the clock care supervised by R.N.'s
- ✲ Private and semi-private rooms; 42 beds
- ✲ Occupational and physical therapy
- ✲ Piped-in oxygen to each bed
- ✲ Private 2-way intercom to nurses' station
- ✲ Recreation lounge with TV
- ✲ Dietary needs supervised by trained dietitian

Refer your patients to Kahanaola for
CARE . . . BY THOSE WHO CARE

*For information, write: Administrator*
**KAHANAOLA CONVALESCENT HOSPITAL**
45-090 Namoku St., Kaneohe, Hawaii • Phones: 241-670 / 246-211

**ENDORSED BY:** Hawaii State Nursing Home Association, Hospital Association of Hawaii, American Nursing Home Association

# Soyalac

## SOLVES THE PROBLEM

for the infant who requires a milk-free diet!




- Soyalac satisfies! Baby is happy, mother is grateful, doctor is gratified.
- The nut-like taste is pleasing. Infants readily accept this hypoallergenic formula that is completely fibre-free. An exclusive process results in a consistency much like milk.
- Soyalac is strikingly similar to mother's milk in composition and ease of assimilation. Clinical data furnish evidence of Soyalac's value in promoting normal growth and development.
- Excellent for regular infant feeding, too—and for growing children and adults.

Soyalac

*Free Booklet and Samples*

A request on your professional letterhead or prescription form will bring to you complete information and a supply of samples.

a product of

**LOMA LINDA FOODS**

**MEDICAL PRODUCTS DIVISION**

RIVERSIDE, CALIFORNIA

Mount Vernon, Ohio, U.S.A.

# Our "Angels"


Page

Abbott Laboratories
*Enduron, Endronyl, Eutron, and Eutonyl*.....Insert (between 344 & 345)
Amfac, Inc. .....278
American Tobacco Company
*Tareyton* .....282
Ames Company, Inc.
*Dextrostix* .....283
*Labstix* .....345
Ayerst Laboratories
*Premarin* .....368
Bishop Trust Company.....275
Bristol Laboratories
*Polycillin* .....342, 343
*Tetrex-F* .....273
Burroughs Wellcome & Co. (U.S.A.) Inc.
*Polysporin* .....355
Carnation Co. .....287
Ciba Pharmaceutical Co.
*Doriden* .....328
Coca-Cola Bottling Co. of Honolulu.....348
Eastman Kodak Co.....290, 291
Geigy Pharmaceuticals
*Preludin* .....280, 281
*Tandearil* .....348, 349
General Diagnostics
*Simplastin* .....329
Hawaii Medical Service Association.....354
Hawaiian Airlines .....344
Health-Mor, Inc.
*Filter Queen* .....293, 294, 295
Hynson, Westcott & Dunning, Inc.
*Lutrexin* .....271
Kahanolu .....364
Lederle Laboratories
*Tine Test* .....335
Lilly, Eli, & Co.
*Cordran—Half Strength* .....300
*Darvon Compound-65* .....269
*Ilosone* .....356, 357, 358
*V-Cillin K* .....284, 285, 286

Page

Loma Linda Foods
*Soyalac* .....365
Mead Johnson Laboratories
*Prosobee* .....339, 340, 341
Medical Industries .....366
Medical Placement Bureau.....344
Merrell, The Wm. S., Co.
*Alertonic* .....350, 351
O'Leary, Lydia, of Hawaii
*Covermark* .....334
Optical Dispensers of Hawaii, Inc.....352
Parke, Davis & Co.
*Chloromycetin* .....270
Pitman-Moore
*Novahistine-LP* .....336, 337
Robins, A. H., Co., Inc.
*Albee with C*.....Insert (between 282 & 283)
*Donnatal*.....Insert (between 282 & 283)
*Ambar*.....Insert (between 292 & 293)
*Dimetapp*.....Insert (between 292 & 293)
*Phenaphen with Codeine*.....353
Roche Laboratories
*Librium* .....367
Schuman Carriage Co., Ltd.
*Cadillacs* .....359
Searle, G. D., & Co.
*Pro-Banthine* .....288
Sheraton Hotels .....338
Star-Bulletin Printing Co.....352
Stuart Company, The
*Mylanta* .....279
Syntex Laboratories, Inc.
*Norinyl-1* .....346, 347
*Synalar* .....296, 297, 298, 299
Williams Mortuary .....361
Wine Advisory Board.....292
Winthrop Laboratories
*NegGram* .....360
Wyeth Laboratories
*Equagesic* .....362, 363
*Equanil* .....332, 333
*Pen Vee K* .....289
*Serax* .....276, 277



**MEDICAL INDUSTRIES, LTD.**

**949 McCully Street, Room 11** **Phone 990-396**

ZIMMER

HALLMARK

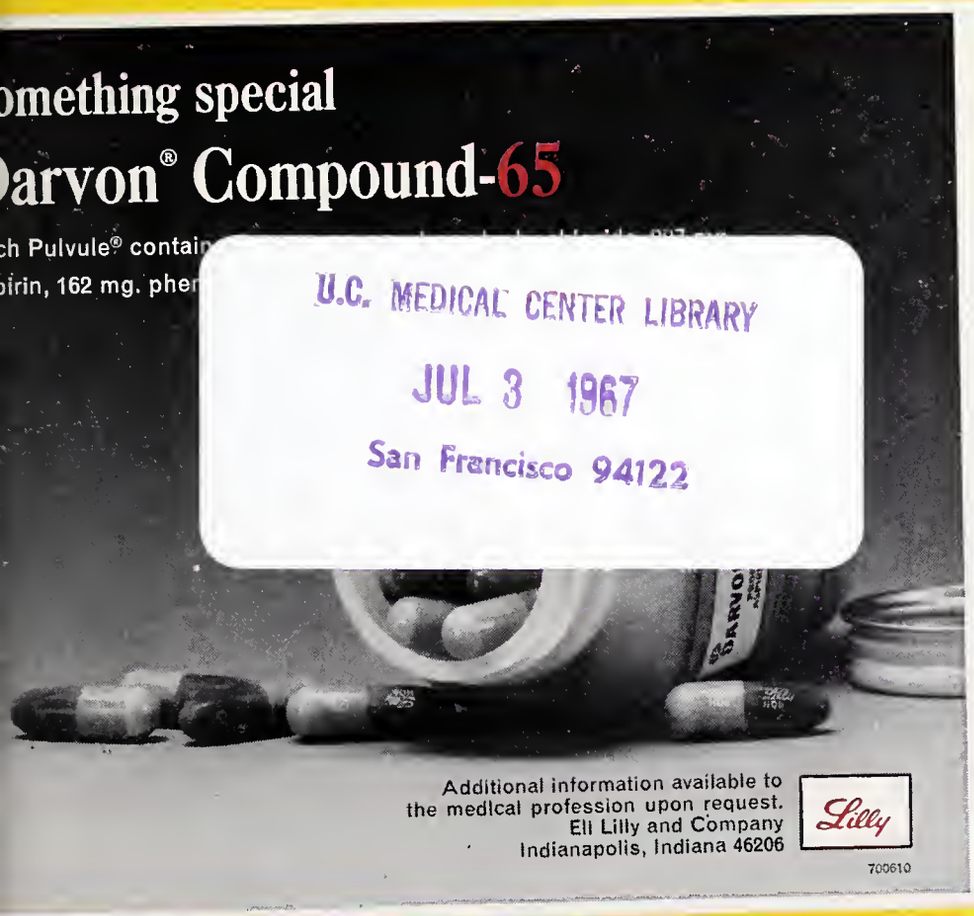
STRYKER

MILTEX

MISDOM-FRANK

May-June, 1967

# HAWAII MEDICAL JOURNAL




*In this issue*

## St. Francis Hospital Issue

*Table of contents, page 374*

VOLUME 26 • NUMBER 5




Whether the allergen is greenish or garish, unseen or unknown, your patient can get symptomatic relief with BENADRYL—the potent antihistamine with antispasmodic action. *INDICATIONS:* Antihistaminic, antispasmodic, antitussive, and antiemetic therapy. *PRECAUTIONS:* Persons who have become drowsy on this or other antihistamine-containing drugs, or whose tolerance is not known, should not drive vehicles or engage in other activities requiring keen response while using this product. Hypnotics, sedatives, or tranquilizers if used with diphenhydramine hydrochloride should be prescribed with caution because of possible additive effect. Diphenhydramine has an atropine-like action which should be considered when prescribing diphenhydramine hydrochloride. *ADVERSE REACTIONS:* Side effects are generally mild and may affect the nervous, gastrointestinal, and cardiovascular systems. Drowsiness, dizziness, dryness of the mouth, nausea, nervousness, palpitation, blurring of vision, vertigo, headache, muscular aching, thickening of bronchial secretions, restlessness, and insomnia have been reported. Allergic reactions may occur.

BENADRYL is available in Kapseals® of 50 mg. and Capsules of 25 mg.

00867

The pink capsule with the white band is a trademark of Parke, Davis & Company.

**PARKE-DAVIS**

# Lutrexin®

## HW&D BRAND OF LUTUTRIN

### 3000 UNIT TABLETS

**IN THE TREATMENT OF FUNCTIONAL DYSMENORRHEA AND SELECTED CASES OF PREMATURE LABOR AND 2ND AND 3RD TRIMESTER THREATENED ABORTION**

In controlling abnormal uterine activity, LUTREXIN, the non-steroid "uterine relaxing factor" has been found to be the drug of choice by many clinicians.

No side effects have been reported, even when massive doses (25 tablets per day) were administered.

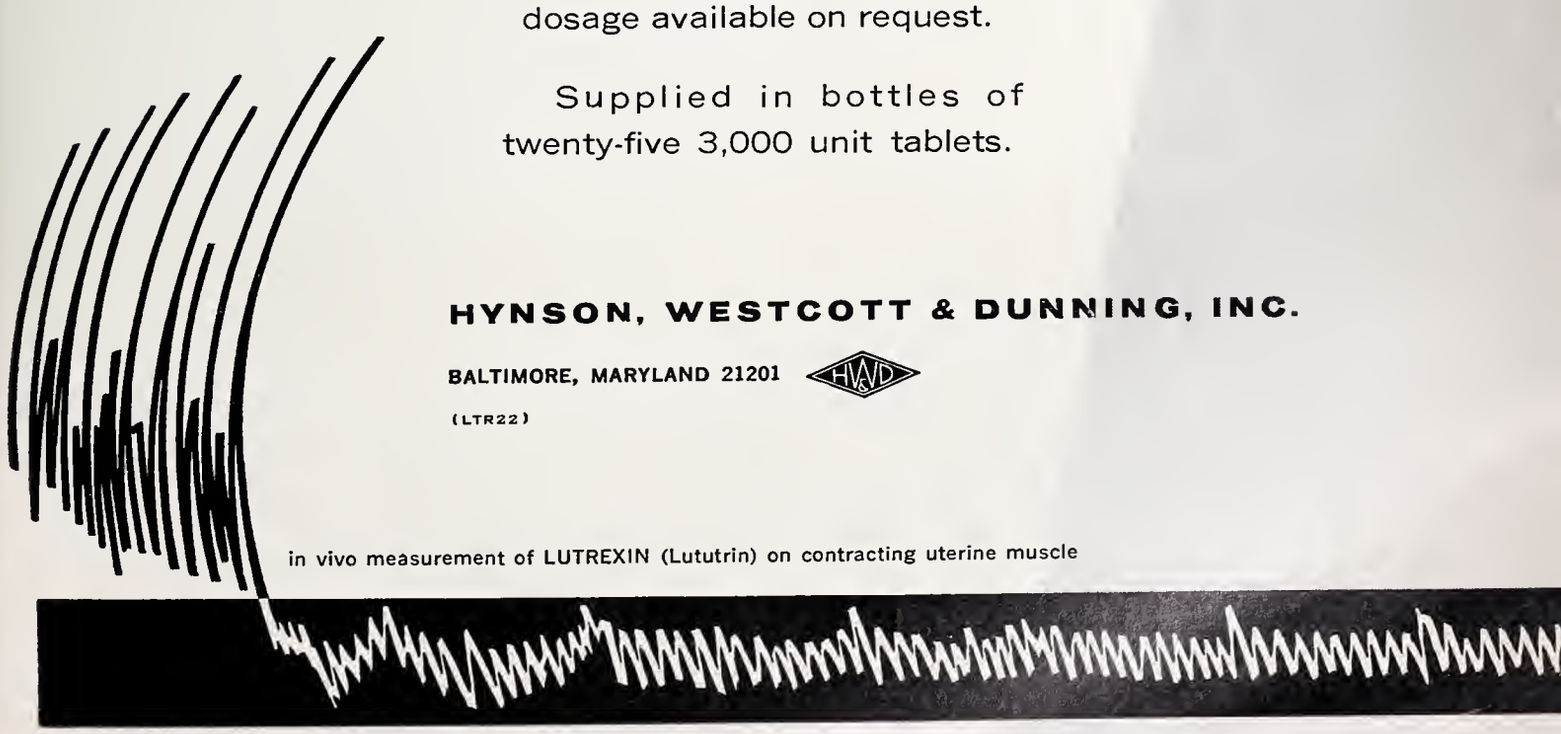
Literature on indications and dosage available on request.

Supplied in bottles of twenty-five 3,000 unit tablets.

**HYNSON, WESTCOTT & DUNNING, INC.**

BALTIMORE, MARYLAND 21201

(LTR22)



in vivo measurement of LUTREXIN (Lututrin) on contracting uterine muscle

HAWAII MEDICAL JOURNAL

*Published Bi-Monthly by the* HAWAII MEDICAL ASSOCIATION (Incorporated in 1856 under the Monarchy), 510 S. Beretania St., Honolulu, Hawaii 96813 • *Editor,* HARRY L. ARNOLD, JR., M.D. • *News Editor,* HENRY N. YOKOYAMA, M.D. • *Managing Editor,* LEE MCCASLIN

VOLUME 26, NUMBER 5 • MAY-JUNE, 1967 • $6.00 A YEAR, $1.00 A COPY

The JOURNAL may not be held responsible for opinions expressed in papers, discussions, communications, or advertisements. The advertising policy of the HAWAII MEDICAL JOURNAL is governed by the rules of the Council on Drugs of the American Medical Association. The right is reserved to reject material submitted for editorial or advertising columns. All material for publication must be in the hands of the editor on or before the 10th day of the month preceding publication date. Reprints of original articles will be supplied at actual cost, provided request is attached to manuscript or made in sufficient time before publication. A reasonable number of cuts and illustrations accompanying an article will be accepted for printing. The right is reserved to ask the author to bear cost of these when it is found neccssary to do so.

Copyright, 1967, by the Hawaii Medical Association, Honolulu, Hawaii. Entered as second class matter, October 17, 1941, at the Post Office in Honolulu, Hawaii, under the Act of August 24, 1912. Office of Publication: Mabel L. Smyth Memorial Building, 510 S. Beretania St., Honolulu, Hawaii 96813.

# The Hawaii Medical Association

## Officers 1967-1968

| | |
|---|---|
| President | B. A. RICHARDSON, *Honolulu* |
| President-Elect | ROBERT M. MIYAMOTO, *Hilo* |
| Past President | THEODORE T. TOMITA, *Honolulu* |
| Secretary | R. VARIAN SLOAN, *Honolulu* |
| Treasurer | HERBERT Y. H. CHINN, *Honolulu* |
| **County Presidents** | |
| Hawaii County | ETTA WRIGHT BEST, *Hilo* |
| Honolulu County | GEORGE H. MILLS, *Honolulu* |
| Kauai County | BURT O. WADE, *Waimea* |
| Maui County | BILLIE FERN STROTHER, *Wailuku* |
| Delegate to A.M.A. | RICHARD D. MOORE, *Honolulu* |
| Alt. Delegate to A.M.A. | GEORGE H. MILLS, *Honolulu* |

## Councillors 1967-1968

| | |
|---|---|
| Maui | WILLIAM E. IACONETTI |
| Honolulu | GROVER H. BATTEN |
| Honolulu | BERNARD W. D. FONG |
| Honolulu | ANDREW C. IVY, JR. |
| Hawaii | DAVID WM. JONES |
| Kauai | SAMUEL R. WALLIS |

## Officers—County Societies—1967

| HAWAII | | HONOLULU |
|---|---|---|
| ETTA WRIGHT BEST | President | GEORGE H. MILLS |
| FRANCIS F. C. WONG | Vice President | KEITH F. O. KUHLMAN |
| REGINALD S. CARVALHO | Secretary | HERBERT Y. H. CHINN |
| JAMES K. MATAYOSHI | Treasurer | K. S. TOM |

| KAUAI | | MAUI |
|---|---|---|
| BURT O. WADE | President | BILLIE FERN STROTHER |
| SAMUEL WALLIS | Vice President | SAKAE UEHARA |
| JAMES P. WARNER | {Secretary} {Treasurer} | JOHN F. MORRIS |

# Soyalac SOLVES THE PROBLEM

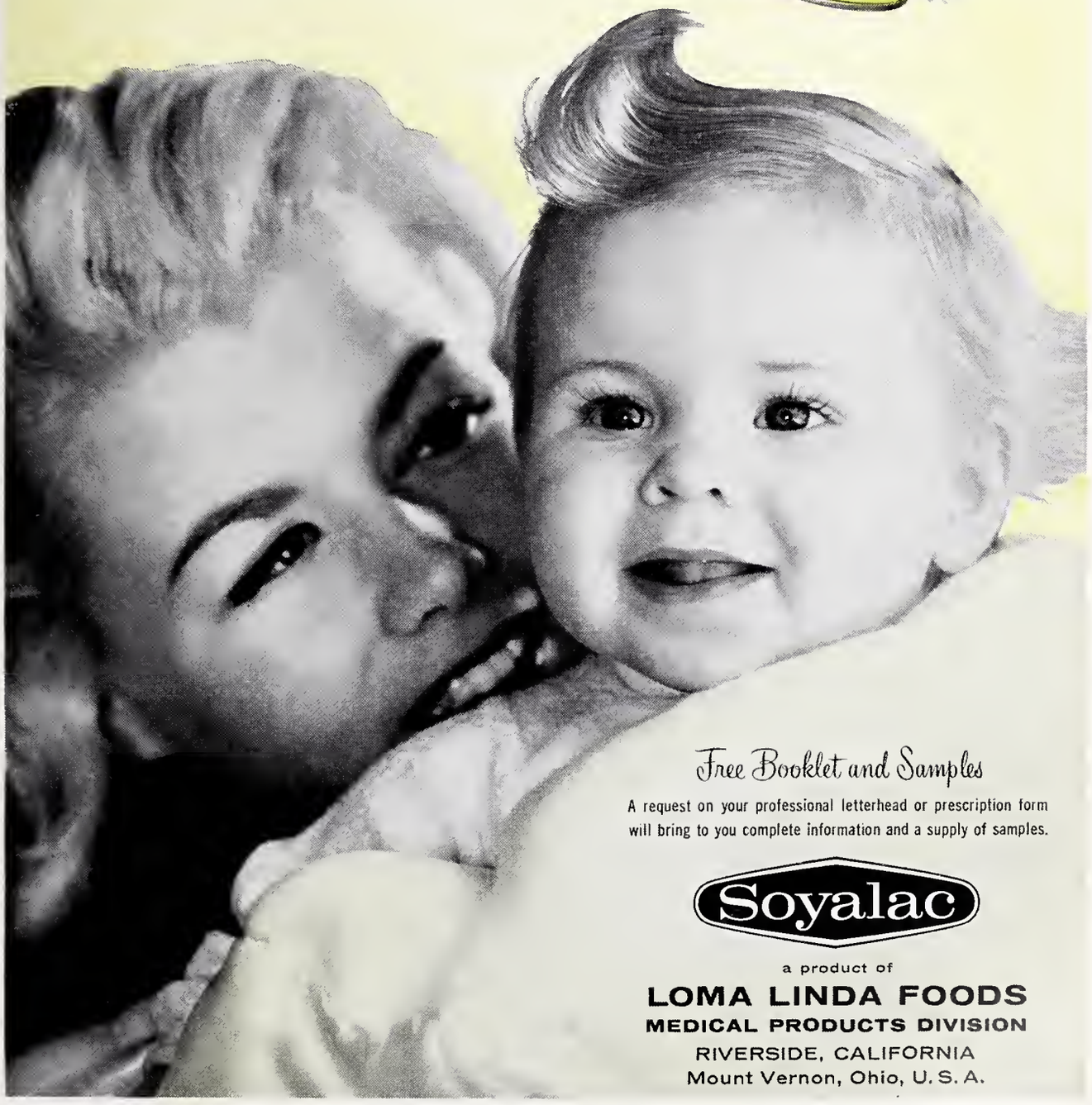
## ...and BABY APPROVES!

Baby has a thing or two to say about a hypo-allergenic, milk-free diet!

Soyalac is the good-tasting, fibre-free formula that infants readily accept. The exclusive Soyalac process results in a consistency much like milk, with a light, creamy color — and nut-like flavor but without a trace of sediment.

Soyalac satisfies the infant. Strikingly similar to mother's milk, it provides protein of high biologic value and balanced nutrients. Clinical data furnish evidence of Soyalac's excellence in promoting normal growth and development.



*Free Booklet and Samples*

A request on your professional letterhead or prescription form will bring to you complete information and a supply of samples.

Soyalac

a product of

**LOMA LINDA FOODS**

**MEDICAL PRODUCTS DIVISION**

RIVERSIDE, CALIFORNIA

Mount Vernon, Ohio, U.S.A.

HAWAII MEDICAL JOURNAL

# Contents

Volume 26, No. 5 • May-June, 1967

**Articles**

*Hand Tumors: A Review* 403
Anthony H. Alter, M.D., and Meryl H. Haber, M.D.

*Cystadenofibroma of the Ovary: Report of a Case* 409
Kunio Miyazawa, M.D., and Frederick S. F. Lee, M.D.

*Complete Vascular Ring As a Cause of Esophageal and Tracheal Compression Review of the Literature and Report of a Case* 412
Manuel A. Abundo, Jr., M.D., and Richard K. S. Pang, M.D.

*Internal Carotid Artery Kinking* 416
Gordon Liu, M.D., William W. T. Won, M.D., and Walter Y. M. Chang, M.D.

*Hepatoma: A Clinical and Pathologic Study of Cases Occurring During 1950-1959 in Hawaii* 418
Paul Y. Tamura, M.D., and Ann B. Catts, M.D.

*Primary Aortoduodenal Fistula Due to Rupture of Aortic Aneurysm* 423
Walter Y. M. Chang, M.D., and Gordon Liu, M.D.

*Intracranial Complications of Otitis Media in This Antibiotic Era: Report of Cases* 426
L. Q. Pang, M.D.

*Carcinoma of the Conjunctiva* 430
Herbert G. Pang, M.D.

*Medulloblastoma: A Case Report* 432
William W. T. Won, M.D.

*Femoropopliteal Artery Reconstruction* 435
Edward K. Lau, M.D., and Richard K. S. Pang, M.D.

**Editorials**

*St. Francis Hospital Takes a Bow* 401
*Planning for Future Medical Care* 402
*Home Care Program* 439
*Dietitians and the Medical Team* 439

**Features**

*Book Reviews* 443
*County Society Reports* 444
*Hawaii Medical Association* 445
*Hawaii Academy of General Practice* 440
*In Memoriam—Doctors of Hawaii* 442
*New Members* 444
*Notes and News* 446
*President's Page* 438
*This Is What's New!* 441

**Hawaii Technologists' Bulletin**

*Automation—Continued* 458
*Graduate Education* 458

# For help in managing your securities now... or to build for your future retirement years...

***. . . see the investment experts at BISHOP TRUST***

Medical men know the value of *specialization*. They also know how important *objectivity* can be in dealing with a patient's problems. Specialization and objectivity are important characteristics of Bishop Trust services, too.

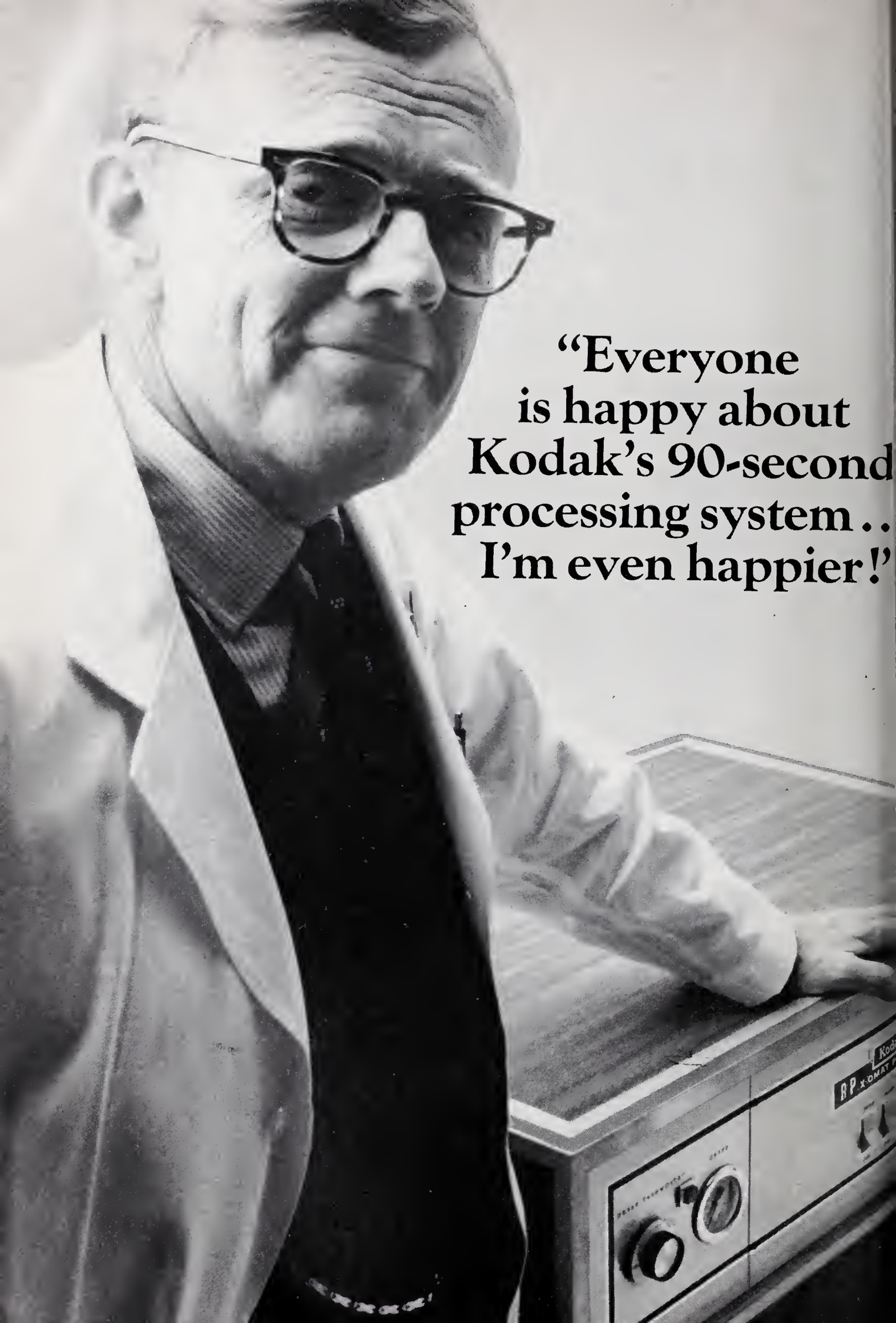
Our staff is made up of men who specialize in helping busy people manage their financial affairs. And like any good practitioner, we first examine the client's condition, then prescribe a course of action that will prove best for him, both now and in the future.

For professional people concerned with building for retirement, we might suggest Bishop Trust's Retirement Plan for Self-Employed Men and Women. Thanks to recent legislation, contributions up to $2,500 a year will soon be completely deductible for income tax purposes. For complete details, ask for a copy of our new summary of this plan.

Because we are a pure trust company, we can offer our assistance with complete objectivity and impartiality. Our future success depends solely on our ability to provide the best trust services available. Phone us for an appointment, either at your home or in our offices. Of course, there's no obligation.

BISHOP TRUST COMPANY

BISHOP AND KING STREETS · PHONE 563-771
Service to Neighbor Island residents by personal visit


"Everyone
is happy about
Kodak's 90-second
processing system..
I'm even happier!"



This is how the chief radiologist in a medical clinic feels about changing to the KODAK RP X-OMAT® System. "It means faster, less confused service," he reports. "No more traffic snarls at the processor, more efficient use of existing facilities. Less waiting time for patients."

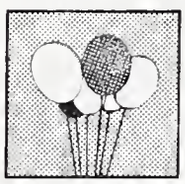
Two new films developed for rapid processing yield clean, brilliant radiographs of high diagnostic readability time after time.

Ask your Kodak Technical Sales Representative about the new KODAK RP X-OMAT Processor, Model M6. Or about converting most existing X-OMAT Processors to the time-saving 90-second cycle.

**EASTMAN KODAK COMPANY**
**Radiography Markets Division**
**Rochester, N.Y.**

Kodak
TRADEMARK

# Glycine seals out what everybody else seals in...



## Air!

Now you can own the world's only vacuum watch that seals out air. Consequently: no moisture condensation . . . no deterioration of fine lubricating oils . . . no air friction . . . no dust . . . no corrosion . . . no mistake about space-age accuracy for astronauts or aquanauts.

You don't believe it? Nobody does until he sees the Glycine Vacuum watch, sealed by the pressure of the earth's own atmosphere. Even the crystal — specially tempered natural glass, is custom made for Glycine.

What a watch! Contemporary, virile in design, self-winding calendar, ours exclusively. Have it in stainless with bracelet, $89.50. In 14K gold bezel, $99.50, or in 18K gold, $175.




*(pressurized to 650′ under water)*

*"OVER 700 STORES TO SERVE YOU"*

DOWNTOWN
1045 BISHOP ST.

OPEN AN ACCOUNT
CONVENIENT TERMS

ZALE'S®
JEWELERS

KAILUA
KAILUA SHOPPING CENTER

AMERICA'S
LARGEST JEWELERS



# normal activity...promptly with

# LOMOTIL®

LIQUID / TABLETS

Each tablet and each 5 cc. of liquid contains:
diphenoxylate hydrochloride .....2.5 mg.
(Warning: may be habit forming)
atropine sulfate .....0.025 mg.

## in childhood diarrhea associated with: Gastroenteritis • Spastic bowel • Influenza-like infections • Antibiotic administration

Lomotil gets children with diarrhea off toast and tea and back to normal diets and normal activity with gratifying dispatch.

Lomotil slows the rapid propulsion of overstimulated intestines, permits absorption of excess fluid and controls diarrhea with notable promptness and effectiveness.

Moreover, lowered motility achieved with Lomotil relieves the abdominal cramps and discomfort so distressing to children.

*Dosage:* The recommended initial *daily dosages*, given in divided doses until diarrhea is controlled, are:

**Children: Total Daily Dosage**

3-6 mo. . .½ tsp.* t.i.d. (3 mg.)
6-12 mo. .½ tsp. q.i.d. (4 mg.)
1-2 yr. . . .½ tsp. 5 times daily (5 mg.)
2-5 yr. . . .1 tsp. t.i.d. (6 mg.)
5-8 yr. . . .1 tsp. q.i.d. (8 mg.)
8-12 yr. . .1 tsp. 5 times daily (10 mg.)
**Adults:** . .2 tsp. 5 times daily (20 mg.)
(or 2 tablets q.i.d.)

*Based on 4 cc. per teaspoonful.

Maintenance dosage may be as low as one-fourth the initial daily dosage.

*Precautions:* Lomotil is a Federally exempt narcotic preparation of very low addictive potential. Recommended dosages should not be exceeded, and medication should be kept out of reach of children. Should accidental overdosage occur signs may include severe respiratory depression, flushing, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils and tachycardia. Lomotil should be used with caution in patients with impaired liver function or those taking addicting drugs or barbiturates.

*Side Effects:* Side effects are relatively uncommon but among those reported are gastrointestinal irritation, sedation, dizziness, cutaneous manifestations, restlessness, insomnia, numbness of the extremities, headache, blurring of vision, swelling of the gums, euphoria, depression and general malaise.

SEARLE *Research in the Service of Medicine*


Preludin
phenmetrazine
hydrochloride

# helps keep calories at arm's length



Most persons have a tendency to regain lost weight easily. Preludin is made to order for such patients. It effectively curbs appetite and helps them stick to their diets.

*Preludin keeps patients active.* Because moderate exercise is usually more feasible for patients who are not grossly overweight, Preludin should be doubly beneficial for them. It promotes a sense of well-being that activates patients...makes them feel like doing things...and prompts them to get the exercise your weight-control program calls for.

*Preludin effectively reduces appetite*. Preludin's ability to help patients shed weight has been described in more than 300 published clinical reports involving more than 10,000 patients. It will work in your weight-control programs too.

Preludin® tablets of 25 mg.
Endurets® prolonged-action tablets of 75 mg.
*Dosage:* One 25 mg. tablet two or three times daily, or one 75 mg. Endurets tablet once daily.
*Contraindications:* Severe coronary artery disease, hyperthyroidism, severe hypertension, nervous instability, and agitated prepsychotic states. Do not use with other CNS stimulants, including MAO inhibitors.
*Warning:* Do not use during the first trimester of pregnancy unless potential benefits outweigh possible risks.
*Precautions:* Use with caution in moderate hypertension and cardiac decompensation. Cases involving abuse of or dependence on phenmetrazine hydrochloride have resulted in a psychotic illness manifested by restlessness, mood or behavior changes, hallucinations, or delusions. Do not exceed recommended dosage.
*Side Effects:* Dryness or unpleasant taste in the mouth, urticaria, and (rarely) overstimulation, insomnia, dizziness, nausea, urinary frequency or nocturia, or headache.
For complete details, please see full Prescribing Information. (B)46-560A

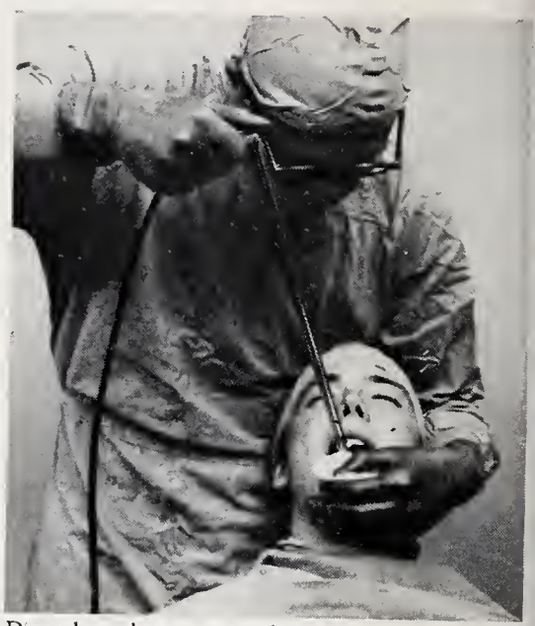
Under license from Boehringer Ingelheim G.m.b.H.

Geigy Pharmaceuticals, Division of
Geigy Chemical Corporation, Ardsley, New York

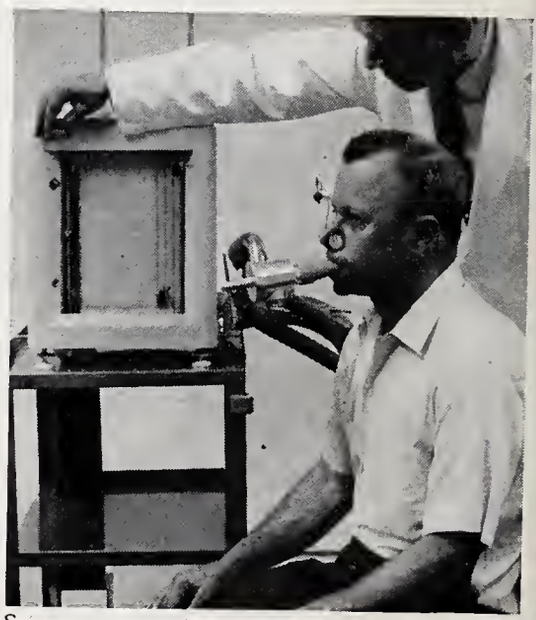
# In chronic respiratory infections:



Diffused mottling in lower right lobe consistent with bronchopneumonia.



Direct bronchoscopy reveals a chronic inflammatory response.



Spirometer measuring pneumo-capacity, useful in evaluating degree of emphysema.

# You can minimize recurrence with this single bactericidal broad-spectrum agent.

Now, instead of tetracycline, penicillin-streptomycin or chloramphenicol, you can use a single broad-spectrum antibiotic—Polycillin (ampicillin trihydrate)—against bacterial infections in pulmonary emphysema, chronic bronchitis and pneumonia.[1-6] Bactericidal against *D. pneumoniae*, Polycillin (ampicillin trihydrate) is also more active than tetracycline or chloramphenicol against *H. influenzae* and many other Gram-negative pathogens. It is well tolerated and without direct toxicity in high or prolonged dosage.

Chronic bronchitis, where pneumococci often accompany the predominant *H. influenzae*, is thus a major indication for Polycillin (ampicillin trihydrate).[4] And when pneumococci are the sole pathogens, controlled clinical trial has shown that it can produce early defervescence more often than parenteral penicillin-streptomycin.[5] While Polycillin (ampicillin trihydrate) cannot reverse structural pathology, it does offer a new and practical way to minimize the chronicity of associated bacterial respiratory infection.

References: 1. May, J. R.: Postgrad. M. J. *40*:193, Suppl., (Dec.) 1964. 2. Millard, F.J.C.: Geriatrics *20*:854 (Oct.) 1965. 3. Lyons, H.A.: M.Times *93*:1386 (Dec.) 1965. 4. Council on Drugs: JAMA *191*:1071 (Mar. 29) 1965. 5. Crofton, J.W., *et al.*: Brit. M.J. *1*:1329 (May 28) 1966. 6. Lyons, H.A.: JAMA *194*:1234 (Dec. 13) 1965.

BRISTOL

BRISTOL LABORATORIES/Division of Bristol-Myers Co. Syracuse, New York

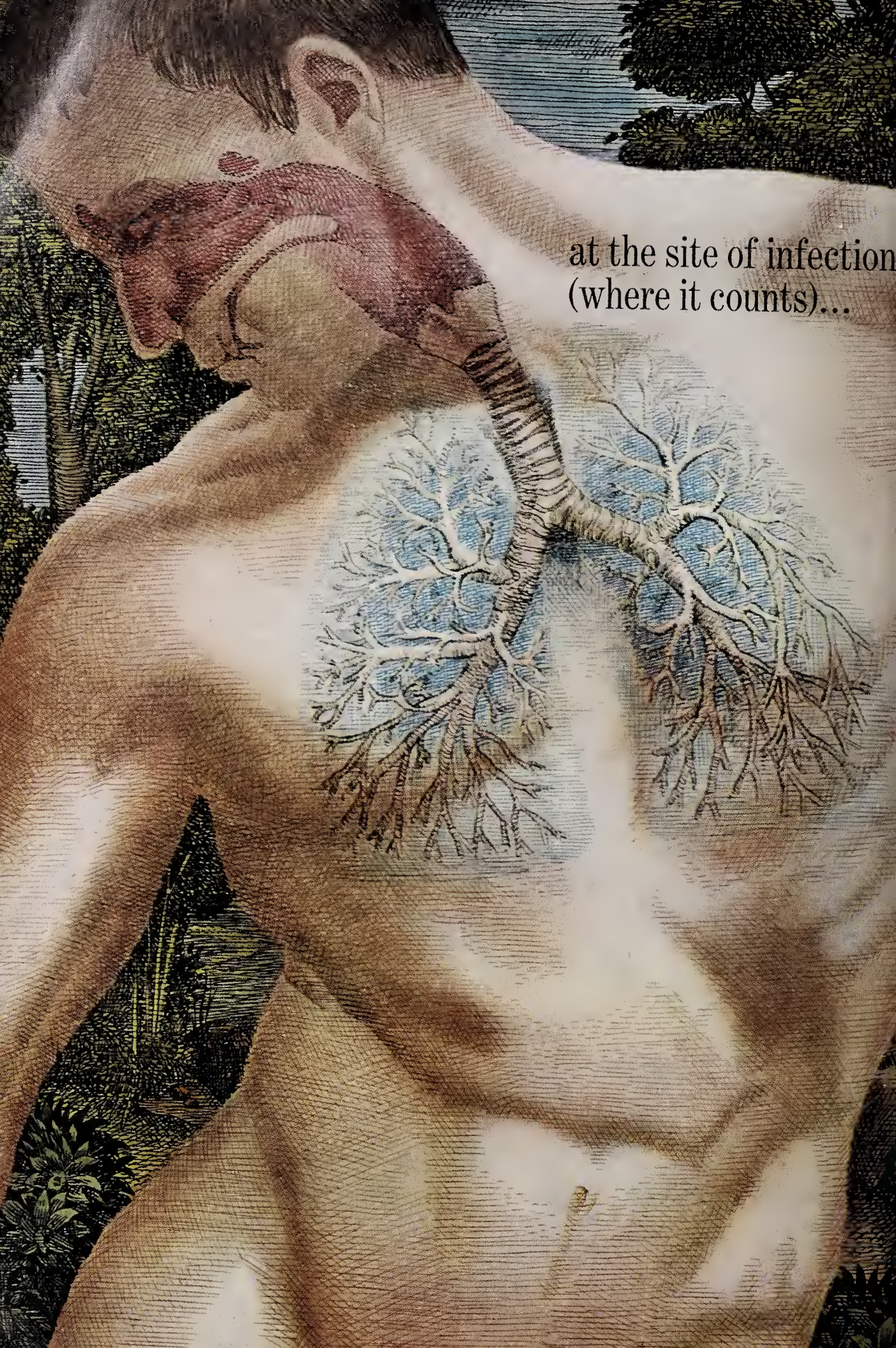
PRESCRIBING INFORMATION. For complete information consult Official Package Circular. *Indications:* Infections due to susceptible strains of Gram-negative bacteria (including Shigellae, *S. typhosa* and other Salmonellae, *E. coli*, *H. influenzae*, *P. mirabilis*, *N. gonorrhoeae* and *N. meningitidis*) and Gram-positive bacteria (including streptococci, pneumococci and nonpenicillinase-producing staphylococci). *Contraindications:* A history of allergic reactions to penicillin and infections due to penicillinase-producing organisms. *Precautions:* Typical penicillin-allergic reactions may occur, especially in hypersensitive patients. Mycotic or bacterial superinfections may occur. Experience in newborn and premature infants is limited and caution should be used in treatment, with frequent organ function evaluations. Safety for use in pregnancy is not established. In gonorrheal therapy, serologic tests for syphilis should be performed initially and monthly for 3 months. Assess renal, hepatic and hematopoietic function intermittently during long-term therapy. *Adverse Reactions:* Skin rash, pruritus, urticaria, nausea, vomiting, diarrhea and anaphylactic reactions. Mild transient elevations of SGOT or SGPT have been noted. *Usual Dosage:* Adults —250 or 500 mg. *q.* 6 *h.* (according to infection site and offending organisms). Children—50-100 mg./Kg./day in 3 to 4 divided doses (depending on infection site and offending organisms). Children weighing more than 20 Kg. should be given an adult dose. Beta-hemolytic streptococcal infections should be treated for at least 10 days. *Supplied:* Capsules—250 mg. in bottles of 24 and 100. 500 mg. in bottles of 16. For Oral Suspension—125 mg./5 ml. in 60, 80, and 150 ml. bottles. 250 mg./5 ml. in 80 ml. bottles. Injectable—for I.M./I.V. use—vials of 125 mg., 250 mg., 500 mg., and 1 Gm.

A.H.F.S. Category 8:12.16

**Polycillin®**

(ampicillin trihydrate)

the penicillin you use like a broad-spectrum antibiotic


at the site of infection
(where it counts)...

# Ilosone® provides more antibacterial activity than any other oral erythromycin

**Acid stable, better absorbed... Ilosone produces faster, higher, more prolonged blood levels, even in the presence of food**[1-3]

Because it is the most active form of oral erythromycin, Ilosone can help assure consistently greater antibacterial activity at the site of infection. Ilosone produces peak antibacterial blood levels two to four times those of other erythromycin preparations.[1,2] Not only are these levels attained earlier, but they are maintained for much longer periods. Even the presence of food does not seem to affect the activity of Ilosone.[1,3]

In the treatment of patients with bacterial infections susceptible to erythromycin, Ilosone has compiled an excellent therapeutic record. Since it exerts its greatest activity against gram-positive organisms, it is particularly useful in common respiratory and soft-tissue bacterial infections. Ilosone kills—not merely inhibits—streptococci, pneumococci, and more strains of staphylococci than any other macrolide antibiotic. This bactericidal action, coupled with the high antibacterial levels attained, makes Ilosone especially valuable in patients with low host resistance, such as infants, debilitated individuals, and diabetics.

Ilosone has shown no cross-resistance with penicillin and may be effective against organisms that have become resistant to that agent. Despite its high antibacterial activity, Ilosone has demonstrated a low incidence of side reactions. Blood dyscrasias, ototoxicity, and tooth staining have not been observed. Infrequent cases of drug idiosyncrasy, manifested by a cholestatic jaundice, have occurred, but there have been no known definite residual effects.

**Ilosone®**
**Erythromycin Estolate**

Lilly

*(See next page for prescribing information.)*

# Ilosone®/ the most active oral form of erythromycin

**Description:** Ilosone is the most active form of oral erythromycin that has been developed. Because it is stable in acid, well absorbed, and excreted in lesser amounts in the bile, it provides faster, higher, and longer-lasting levels of antibacterial activity (ABA) in the serum, even when taken with food, than do comparable doses of erythromycin.

**Indications:** Ilosone is indicated in infections caused by microorganisms sensitive to its action (especially staphylococci, hemolytic streptococci, and pneumococci). The drug is therefore useful in a high proportion of bacterial diseases encountered in clinical practice and particularly in the treatment of bacterial infections of the upper and lower respiratory tract and soft tissues.

In the treatment of acute bacterial pharyngitis and tonsillitis, this antibiotic has promptly eradicated the bacteria (streptococci) and has produced a parallel prompt clinical improvement. There have been no group A beta-hemolytic streptococci resistant to this preparation. In beta-hemolytic streptococcus infections, treatment should be maintained for ten days to prevent the development of rheumatic fever or glomerulonephritis.

Erythromycin estolate has proved to be very effective in pneumococcus pneumonia and in acute bronchitis with pneumococci on culture. Bronchopneumonia and otitis media in children have responded well to its use.

The antibiotic has been used very successfully in staphylococcus infections. Good therapeutic results have been obtained in soft-tissue infections, abscesses, cellulitis, carbuncles, wound infections, and furunculosis.

In serious staphylococcus infections, erythromycin preparations should be used only in combination therapy with other antimicrobial agents. As is the case with any treatment regimen used in these severe conditions, surgical procedures should be performed when indicated, and large dosages of the antimicrobial agents should be employed. In this fashion, Ilosone has been effective in staphylococcus pneumonia, osteomyelitis, septicemia, empyema, and meningitis.

Multiple 500-mg. doses of the drug have been useful in gonorrhea and syphilis. Since penicillin is the drug of choice for the treatment of syphilis and gonorrhea, erythromycin estolate should be employed for these infections only in patients with a history of penicillin allergy. Also, other infections due to susceptible bacteria in patients known to be hypersensitive to penicillin or other antibiotics may be considered for treatment with Ilosone.

**Contraindications: Ilosone is contraindicated in patients with a known history of sensitivity to this drug and in those with preexisting liver disease or dysfunction.**

**Side-Effects:** Data obtained from seven years' use of propionyl erythromycin ester and erythromycin estolate (Ilosone) indicate that hepatic dysfunction with or without clinical jaundice may occur during or following courses of therapy with the drug.

Changes in liver function tests in such cases have been indicative of intrahepatic cholestasis. The symptoms appear to be the result of a form of sensitization. The initial symptoms have appeared in some cases after a few days of treatment but generally have followed one or two weeks of continuous therapy or several courses of the drug. Symptoms reappear promptly if the drug is readministered to sensitive patients, usually within forty-eight hours. Eosinophilia was noted in peripheral blood counts. The findings readily subsided without apparent residual effects when treatment was discontinued. Recovery was delayed in one reported instance. The physician indicated in this case that either drug-induced jaundice or viral hepatitis may have been responsible for the findings.

In one clinical study involving ninety-three patients treated with the antibiotic, three cases of jaundice were observed and an additional eleven cases developed some changes in liver function tests. Three of the patients had abnormal liver function tests a second time on readministration of the drug.

Even though it is assumed that not all cases of jaundice have been reported, it seems clear that the number is small compared with the amount of drug that has been used. Reported cases have included persons in whom there had been administered other drugs known to be associated at times with hepatic side-effects and cases in which the presence of viral hepatitis or other disease may have been responsible for the findings. In some of the cases, associated gastro-intestinal symptoms simulated the colic of biliary tract disease. In other instances, clinical symptoms and results of liver function tests resembled findings in extrahepatic obstructive jaundice. It appears that the occurrence of jaundice after administration of Ilosone is infrequent, but further investigations are being made to estimate its incidence more accurately.

In those cases mentioned above in which jaundice appeared to be definitely related to use of the drug, laboratory findings we characterized by increased direct-reacting bilirubin, elevat alkaline phosphatase levels, negative or weakly positive cepha flocculation and thymol turbidity tests, elevated serum glutan oxalacetic transaminase levels, peripheral eosinophilia, and nc mal cholecystograms.

Individual idiosyncrasy seems evident since jaundice has r been reported in other patients taking prolonged courses of t medication. Patients with chronic infection have been given 1 to 2 Gm. of the drug daily for periods of two to six months, a patients with rheumatic fever have taken prophylactic doses 0.5 Gm. daily for two years without difficulty. In one group 144 patients who received the drug daily for two years, no jau dice was noted. It was of interest that members of six of the patients' families, who were not taking the drug, had episod of jaundice during the study period.

Transaminase and serum alkaline phosphatase levels we determined in a group of fifty-four adults and children who to 250 mg. of Ilosone daily for an average of sixteen months rheumatic fever prophylaxis. The results were compared wi those of a similar group of forty-four patients who received pe icillin. There were no cases of jaundice in either group. Elevatic of SGPT and serum alkaline phosphatase levels during the cour. of treatment was observed in one patient treated with Ilosoi and in two patients treated with penicillin. Seven other patien in the group receiving Ilosone and four others in the penicilli group showed elevations in one of the tests at some time durin administration of the drugs.

Very satisfactory therapeutic results, without toxicity, wei reported in 102 pediatric patients who received short-term (te day) courses of Ilosone in the treatment of streptococcus infe tions. Results of liver function tests in these patients were com parable to those in a similar control group who had receive penicillin.

Gastro-intestinal disturbances not associated with hepatic e fects are observed in a small proportion of individuals as a resul of a local stimulating effect of the medication on the alimentar tract; however, the normal intestinal gram-negative bacteria flora is not appreciably altered by erythromycin drugs.

Although allergic manifestations are uncommon with the us of erythromycin, there have been occasional reports of urticaria skin eruptions, and, on rare occasions, anaphylaxis.

**Administration and Dosage:** Ilosone is administered orally.

Ilosone Pulvules®
Ilosone Chewable Tablets
Ilosone Drops
Ilosone, 125, for Oral Suspension

For infants and for children under twenty-five pounds of bod weight, the usual dosage is 5 mg. per pound every six hours; fo children twenty-five to fifty pounds, 125 mg. every six hours (Tablets Ilosone Chewable should be chewed or crushed an swallowed with water.)

For adults and for children over fifty pounds, the usual dosag of Ilosone is 250 mg. every six hours.

For severe infections, these dosages may be doubled.

When larger doses are indicated, parenteral erythromycin therapy should be considered.

In the treatment of syphilis, the recommended total dosage is 20 to 30 Gm. given in divided doses for a period of ten to fifteen days. Close follow-up of the patient is necessary since erythromycin drugs have not had adequate evaluation in all stages of syphilis. Examinations of spinal fluid are recommended as part of the follow-up therapy.

For gonorrhea, 500 mg. four times a day for four days are recommended. In the treatment of gonorrhea, patients with a suspected lesion of syphilis should have a dark-field examination before receiving antibiotics, and monthly serologic tests should be made for a period of three months.

**How Supplied:** Pulvules Ilosone, Capsules, N.F., 125 and 250 mg. (equivalent to base), in bottles of 24 and 100.

Tablets Ilosone Chewable, N.F., 125 mg. (equivalent to base), in bottles of 50.

Ilosone Drops, 5 mg. (equivalent to base) per drop, in 10-cc.-size packages, with dropper calibrated at 25 and 50 mg.

Ilosone, 125, for Oral Suspension, N.F., 125 mg. (equivalent to base) per 5-cc. teaspoonful, in 60 and 150-cc.-size packages.

*References:* 1. Griffith, R. S., and Black, H. R.: Am. J. M. Sc., *247*:69, 1964.
2. Griffith, R. S., and Black, H. R.: Antibiotics & Chemother., *12*:398, 1962.
3. Hirsch, H. A., Pryles, C. V., and Finland, M.: Am. J. M. Sc., *239*:198, 1960.

*Additional information available to physicians upon request.*
*Eli Lilly and Company, Indianapolis, Indiana 46206.*

Lilly

700121




Tareyton...with the taste worth fighting for

America's largest-selling charcoal-tip cigarette

©The American Tobacco Company




# in sinusitis, colds, U. R. I.

# Dimetapp® Extentabs®

(Dimetane® [brompheniramine maleate], 12 mg.;
phenylephrine HCl, 15 mg.; phenylpropanolamine HCl, 15 mg.)

## up to 10-12 hours clear breathing on one tablet

**It's clear—Dimetapp lets your "stuffed-up" patients breathe easy again. Each hard-working Extentab brings welcome relief from the stuffiness, drip and congestion of upper respiratory conditions for up to 10-12 hours. Yet, patients seldom experience drowsiness or overstimulation. Its key to success is the Dimetapp formula: Dimetane (brompheniramine maleate)—along with phenylephrine and phenylpropanolamine, two time-tested decongestants. They get the job done...in a hurry.**

**Contraindications:** Hypersensitivity to antihistamines. Not recommended for use during pregnancy. **Precautions:** Until patient's response has been determined, he should be cautioned against engaging in operations requiring alertness. Administer with care to patients with cardiac or peripheral vascular diseases or hypertension. **Side Effects:** Hypersensitivity reactions including skin rashes, urticaria, hypotension and thrombocytopenia have been reported on rare occasions. Drowsiness, lassitude, nausea, giddiness, dryness of the mouth, mydriasis, increased irritability or excitement may be encountered. **Dosage:** 1 Extentab morning and evening. **Supplied:** Bottles of 100 and 500.

A. H. ROBINS COMPANY, Richmond, Virginia 23220

A·H·ROBINS

# There are 7,350* undetected diabetics in Hawaii

Most of these are probably among patients over 40; the overweight; relatives of diabetics, and mothers of large babies. By the time polyphagia, polyuria, polydipsia, pruritus or other overt symptoms of diabetes appear, damage may have been done that could have been minimized. DEXTROSTIX® gives you a reliable blood-glucose estimate in 60 seconds.

# Why Wait?




*Based on Statistical Report, U.S. Dept. Commerce, ed. 86, and Fisher, G. F., and Vavra, H. M.: Pub. Health Rep. 80:961 (Nov.) 1965.
Note: DEXTROSTIX is not meant to replace the more precise analytical laboratory procedures such as needed in glucose tolerance testing.

**AMES COMPANY,** Division Miles Laboratories, Inc., Elkhart, Indiana 46514 428R67

Ames

# In peptic ulcer... antacid therapy with a new benefit



CONTAINS A BALANCED COMBINATION OF THE MOST WIDELY USED ANTACIDS— FOR RAPID NEUTRALIZATION. PLUS SIMETHICONE— TO CONTROL THE FACTOR WHICH ANTACIDS ALONE CANNOT INFLUENCE.

# Mylanta®

- In Mylanta, aluminum and magnesium hydroxides are balanced to minimize the chance of constipation or laxation and still achieve rapid acid neutralization and pain relief.
- The positive action of simethicone helps relieve the painful gas symptoms which often accompany the peptic ulcer syndrome.
- The nonfatiguing flavor and smooth, nongritty consistency of tablets and liquid encourage continued patient cooperation during long-term therapy.

**Composition:** Each Mylanta chewable tablet or teaspoonful (5 ml.) of liquid contains: magnesium hydroxide, 200 mg.; aluminum hydroxide, dried gel, 200 mg.; simethicone, 20 mg. **Dosage:** one or two tablets, well chewed or allowed to dissolve in the mouth, or one or two teaspoonfuls of liquid to be taken between meals and at bedtime.

**The Stuart Company,** Pasadena, California
Division of Atlas Chemical Industries, Inc.

**Stuart**

# Carnation

EVAPORATED MILK

## HAWAII'S HEALTHY BABY MILK...

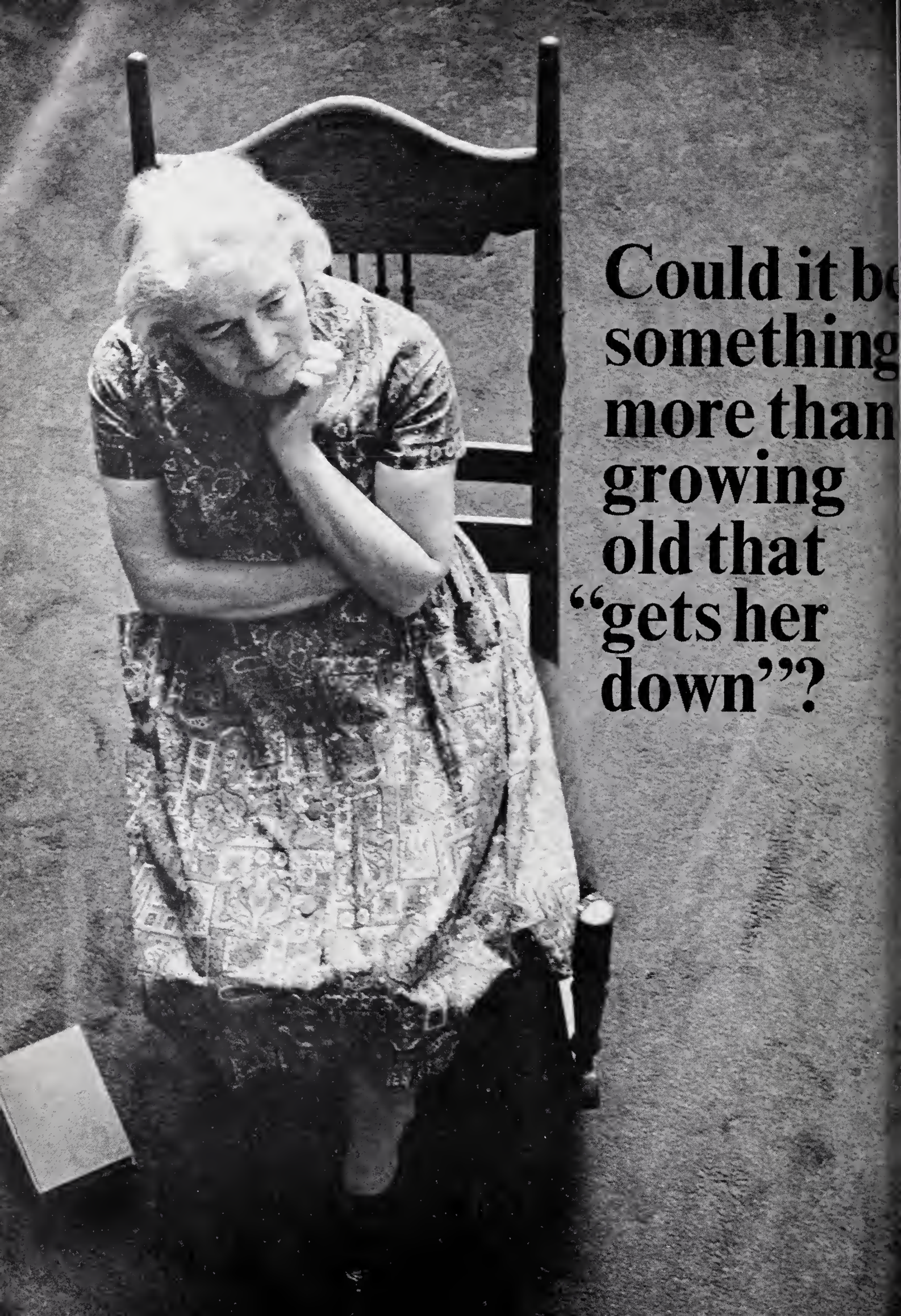



*"from Contented Cows"*



***1st CHOICE FOR INFANT FEEDING...***
***No. 1 in the Islands for generations,***
***...available everywhere in Hawaii***

1966
Carnation Healthy Baby Contest
$1,000 1st prize winner,
Peter David Keaomalamalama Yoshimi Malo
of Honolulu, Hawaii


Could it be
something
more than
growing
old that
"gets her
down"?

**Mild mood depression, poor appetite, little interest in the present or future. Does this picture mean that she's giving in to functional fatigue?**

**When functional fatigue is part of her problem, Alertonic can help counteract accompanying apathy and inertia. It helps lift mood, stimulate appetite, and establish new interest in daily life.**

Pleasant-tasting Alertonic combines pipradrol hydrochloride—a gentle cerebral stimulant—with an excellent vitamin and mineral formula, in a satisfying 15% alcohol vehicle.

Especially in the aging patient, nothing fosters confidence and a sense of well-being better than your own personal warmth, understanding, and encouragement. Between visits, however, your prescription for Alertonic can help keep your patient from giving in to functional fatigue.

*Adequate dosage is important: Prescribe Alertonic—one tablespoonful t.i.d., 30 minutes before meals ...tastes best chilled.*

*And for your patient's sake, prescribe Alertonic in the convenient, economical one-pint bottle.*

Available only on prescription

# Alertonic®

Each 45 cc. (3 tablespoonfuls) contains: alcohol, 15%, pipradrol hydrochloride, 2 mg.; thiamine hydrochloride (vitamin $B_1$) (10 MDR*), 10 mg.; riboflavin (vitamin $B_2$) (4 MDR), 5 mg.; pyridoxine hydrochloride (vitamin $B_6$), 1 mg.; niacinamide (5 MDR), 50 mg.; choline,† 100 mg.; inositol,† 100 mg.; calcium glycerophosphate, 100 mg. (supplies 2% MDR for calcium and for phosphorus) and 1 mg. each of the following: cobalt (as chloride), manganese (as sulfate), magnesium (as acetate), zinc (as acetate), and molybdenum (as ammonium molybdate).

*Multiple of adult Minimum Daily Requirement supplied.
†The need for these substances in human nutrition has not been established.

**Indications:** 1. Functional fatigue such as that often associated with: a depressing experience or stressful time of life; advancing years; convalescence; limited activity or confinement. 2. Poor appetite and vitamin-mineral deficiency as they occur in: patients having faulty eating habits; geriatric patients who are losing interest in food; patients convalescing from debilitating illness or surgery.

**Contraindications:** As with other drugs with CNS stimulating action, Alertonic is contraindicated in hyperactive, agitated or severely anxious patients and in chorea or obsessive compulsive states.

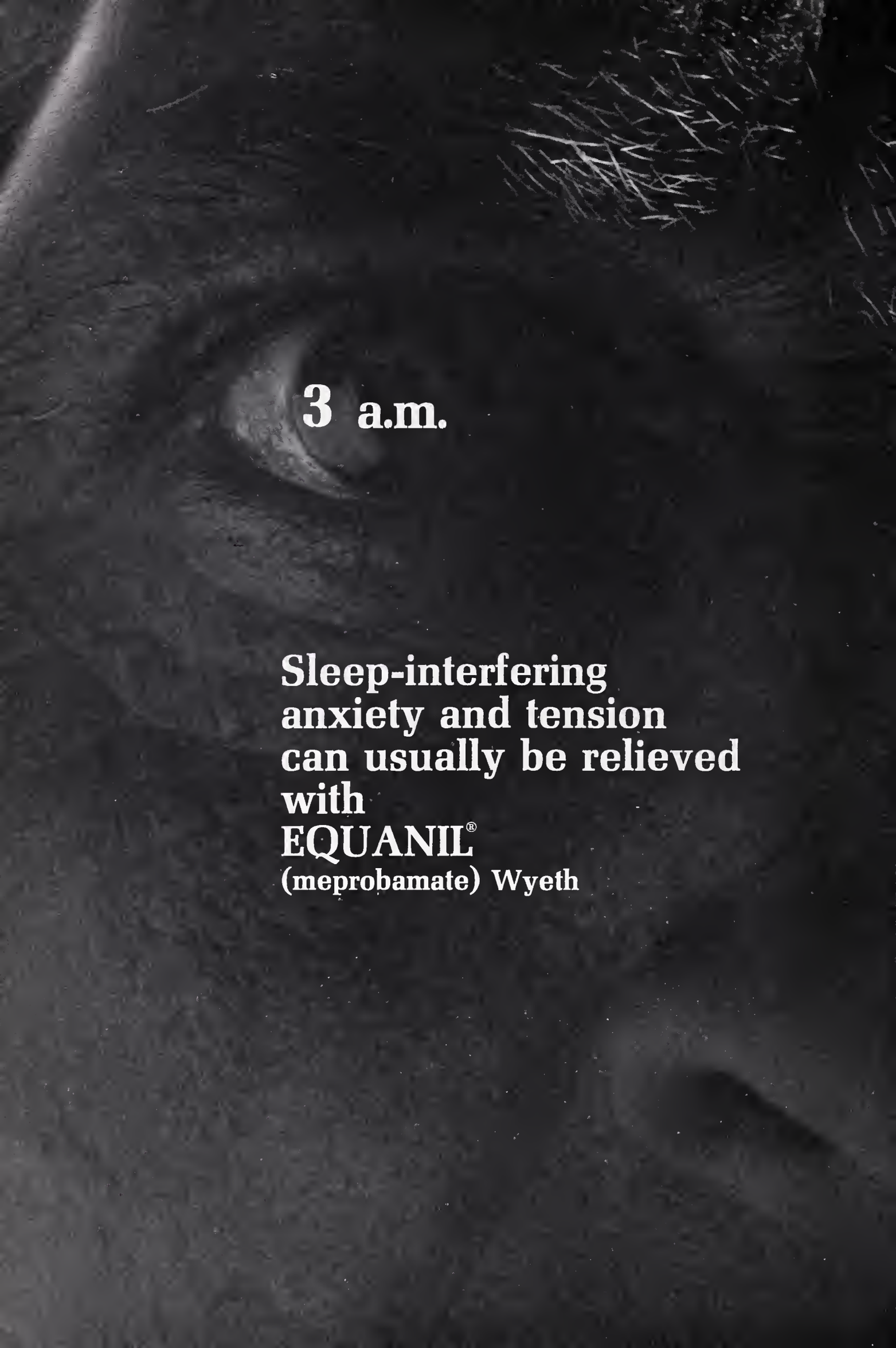
**Side effects:** Reports of overstimulation have been rare. Patients who are known to be unduly sensitive to the effects of stimulant drugs should be observed carefully in the initial stages of treatment.

**Dosage:** Adults, 1 tablespoonful; children (over 15 years old), 1 to 2 teaspoonfuls; children (4 to 15 years old), 1 teaspoonful. To be taken three times daily 30 minutes before meals.

Merrell

THE WM. S. MERRELL COMPANY
Division of Richardson-Merrell Inc.
Cincinnati, Ohio 45215

7-8378


3 a.m.
Sleep-interfering
anxiety and tension
can usually be relieved
with
EQUANIL®
(meprobamate) Wyeth



**Cautions:** Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use may result in dependence or habituation in susceptible persons—as ex-addicts, alcoholics, severe psychoneurotics. After prolonged high dosage, drug should be withdrawn gradually to avoid possibly severe withdrawal reactions including epileptiform seizures. Side effects include drowsiness and, rarely, allergic or idiosyncratic reactions. These reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Mild reactions are characterized by urticarial or erythematous maculopapular rash. Acute non-thrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever have been reported. Meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioneurotic edema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. Warn patients of possible reduced alcohol tolerance. Should drowsiness, ataxia, or visual disturbances occur, dose should be reduced. If symptoms persist, patients should not operate vehicles or dangerous machinery. A few cases of leukopenia, usually transient, have been reported following prolonged dosage. Other blood dyscrasias—aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis and hemolytic anemia—have occurred rarely, almost always in the presence of known toxic agents. One fatal case of bullous dermatitis following intermittent use of meprobamate with prednisolone has been reported. Prescribe very cautiously for patients with suicidal tendencies. Suicidal attempts should be treated with immediate gastric lavage and appropriate supportive therapy.

**Contraindications:** History of sensitivity to meprobamate.

**Composition:** Tablets, 200 mg. and 400 mg. meprobamate. Coated Tablets, WYSEALS® EQUANIL (meprobamate) 400 mg. Continuous-Release Capsules, EQUANIL L-A (meprobamate) 400 mg.

Wyeth Laboratories
Philadelphia, Pa.

Wyeth®
SERVICE TO MEDICINE



*"When I couldn't even smell corned beef and cabbage,*
*I decided it was time for you, Doc."*



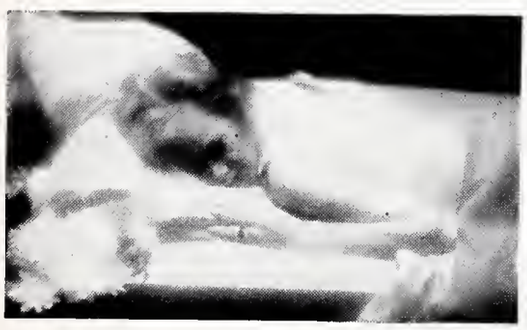
Maybe he doesn't know when he's well off. But you might want to prescribe long-acting Novahistine LP anyway.

Two tablets in the morning and two in the evening will usually provide day and night relief by helping to clear congested air passages for normal, free breathing. Novahistine LP is formulated to provide continuous therapeutic effect for 8 to 12 hours. The decongestant ingredients help restore normal mucus secretion and ciliary activity—physiologic defenses against infection of the respiratory tract. Use cautiously in individuals with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result. Each Novahistine LP tablet contains phenylephrine hydrochloride, 25 mg., and chlorpheniramine maleate, 4 mg.

# NOVAHISTINE® LP

DOW **PITMAN-MOORE** Division of The Dow Chemical Company, Indianapolis

# What a difference a good night's sleep makes



A good night's sleep and all's well with the world. A night of sleepless tossing and the day's pleasant moments lose their luster, routine tasks seem like grinding drudgery.

Count on Doriden to help make the difference. For most patients with insomnia, it provides a good night's sleep, a clear awakening.

# Doriden® (glutethimide CIBA)

**Doriden®** (glutethimide CIBA)

**Indications and Dosage:** *Insomnia*—0.5 Gm at bedtime. *Preoperative Sedation*—0.5 Gm the night before surgery; 0.5 to 1 Gm 1 hour before anesthesia. *Obstetric Sedation*—0.5 Gm at onset of labor.

Continuing total daily dosage over 1 Gm is not recommended.

**Caution:** Supervise dosage carefully, especially in patients with a known propensity for overdosing. Excessive and prolonged use in susceptible persons (e.g., alcoholics, former addicts, severe psychoneurotics) may result in dependence and withdrawal reactions. In those cases, reduce dosage gradually to lessen the likelihood of withdrawal reactions such as nausea, abdominal discomfort, tremors, or convulsions. Newborns of mothers dependent on glutethimide may exhibit withdrawal symptoms.

**Side Effects:** Occasionally, a skin rash may occur; if so, withdraw drug. The rash usually clears spontaneously in 2 or 3 days. Occasionally nausea also occurs. Rarely, acute hypersensitivity reactions and blood dyscrasias have been associated with glutethimide therapy.

**Supplied:** *Tablets*, 0.5 Gm (white, scored) and 0.25 Gm (white, scored); bottles of 100, 500 and 1000. *Tablets*, 0.125 Gm (white); bottles of 100. *Capsules*, 0.5 Gm (blue and white); bottles of 100.

*Consult complete literature before prescribing.* 2/3646 MBL

CIBA Pharmaceutical Company, Summit, N.J. **CIBA**

# Don't let monilia cut broad-spectrum therapy short...

## start with Tetrex-F®

## tetracycline phosphate complex-nystatin

Use of broad-spectrum antibiotics can cause fungal overgrowth in the alimentary tract... and give rise to symptoms so troublesome that therapy must be prematurely stopped. Tetrex-F (tetracycline phosphate complex-nystatin) helps you circumvent this problem.

The nystatin can prevent overgrowth of monilia; the phosphate complex delivers tetracycline to the blood rapidly. Side effects are infrequent.

**High-Risk Patients**

Tetrex-F (tetracycline phosphate complex-nystatin) is especially useful in patients most susceptible to fungal overgrowth during tetracycline therapy: (1) the elderly or debilitated, (2) young children, (3) the diabetic, (4) those on long-term tetracycline therapy, (5) those on steroid therapy, (6) those who have had moniliasis before, and (7) pregnant patients with a history of monilial vaginitis.

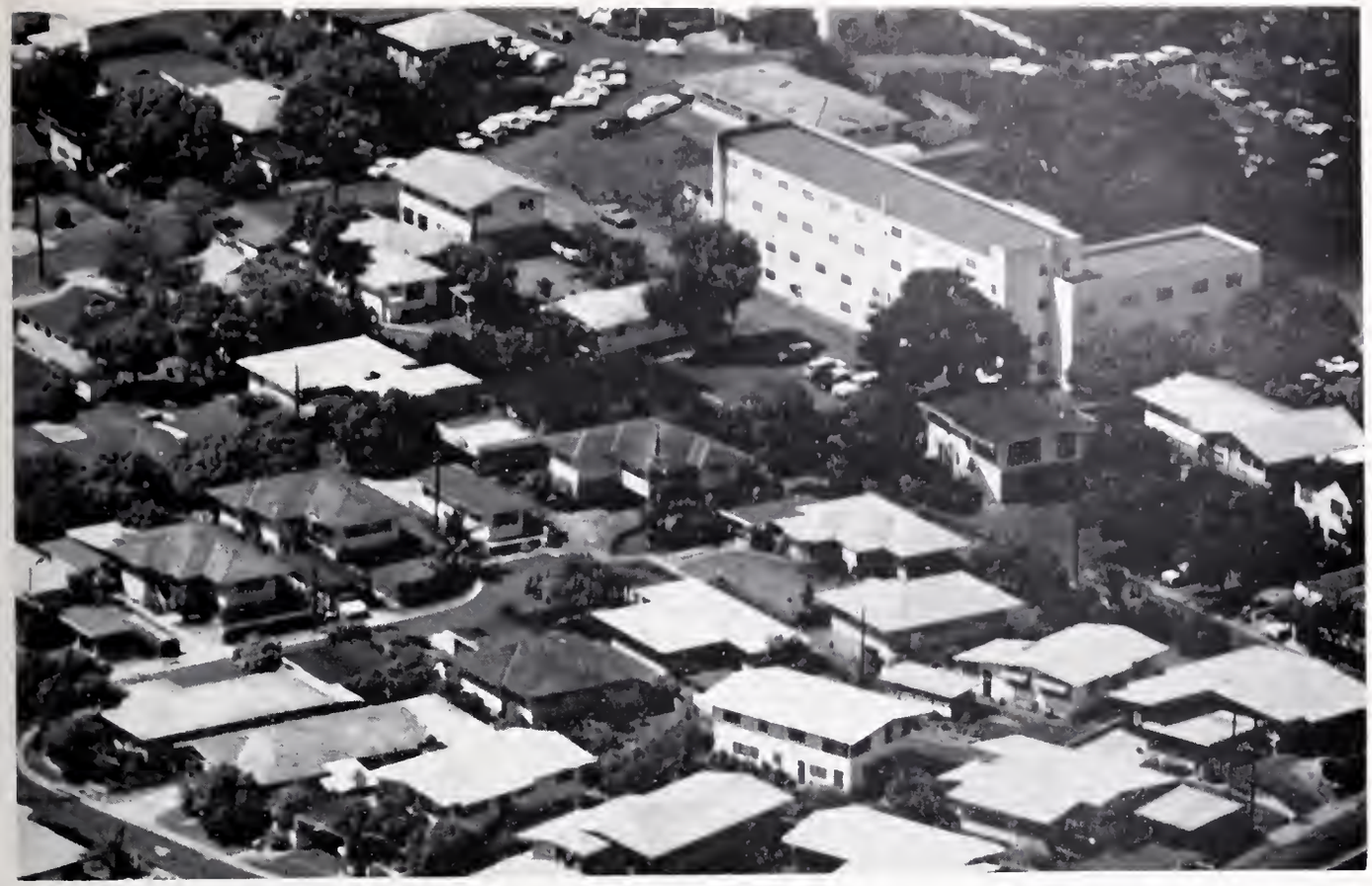
When you start with economical Tetrex-F (tetracycline phosphate complex-nystatin), you can complete the full course of broad-spectrum therapy with less chance of losing control elsewhere. A good start for a healthy finish.

PRESCRIBING INFORMATION. For complete information consult Official Package Circular. *Indications:* Infections of respiratory, gastrointestinal and genitourinary tracts and skin and soft tissues due to tetracycline-sensitive organisms, in patients with increased susceptibility to monilial infections. *Contraindications:* The drug is contraindicated in patients hypersensitive to its components. *Warnings:* Photodynamic reactions have been produced by tetracyclines. Natural and artificial sunlight should be avoided during therapy. Stop treatment if skin discomfort occurs. With renal impairment, systemic accumulation and hepatotoxicity may occur. In this situation, lower doses should be used. Tooth staining and enamel hypoplasia may be induced during tooth development (last trimester of pregnancy, neonatal period and childhood). *Precautions:* Bacterial superinfections may occur. Infants may develop increased intracranial pressure with bulging fontanels. In gonorrheal therapy, serologic tests for syphilis should be conducted initially and monthly for 3 months. *Adverse Reactions:* Glossitis, stomatitis, nausea, diarrhea, flatulence, proctitis, vaginitis, dermatitis, and allergic reactions may occur. *Usual Adult Dosage:* 1 capsule q.i.d. Continue for 10 days in Beta-hemolytic streptococcal infections. Administer one hour before or two hours after meals. *Supplied:* Capsules, bottles of 16 and 100. Each capsule contains tetracycline phosphate complex equivalent to 250 mg. tetracycline HCl activity and 250,000 units of nystatin. For Oral Suspension, 125 mg. tetracycline and 125,000 u. nystatin/5 ml., 60 ml. bottles.

BRISTOL

BRISTOL LABORATORIES
Division of Bristol-Myers Company
Syracuse, New York 13201


for
quick relief
that lasts
and lasts
Co-Pyronil®
Pyrrobutamine Compound
1 PINT (473 cc.)
SUSPENSION
CO-PYRONIL
PYRROBUTAMINE
COMPOUND
100 No. 336
PULVULES
CO-
PYRONIL
PYRROBUTAMINE
COMPOUND
No. 342
PULVULES
CO-PYRONIL
PYRROBUTAMINE
COMPOUND
Pediatric
Additional information available to physicians upon request. ELI LILLY AND COMPANY, INDIANAPOLIS, INDIANA 46206.
Lilly
700807



# St. Francis Hospital Takes a Bow

Honored on its fortieth birthday by this special issue of the HAWAII MEDICAL JOURNAL is St. Francis Hospital, the vigorous third-oldest member of urban Honolulu's team of general hospitals.

Founded in 1927, when The Queen's Hospital was already oer 70 years old and Kuakini Hospital (then the Japanese Hospital) was 27, St. Francis received ACS accreditation in 1929 and graduated its first class of nurses three years later.

Steady expansion followed: a nurses' home in 1941; a new ward in 1942 to raise bed capacity from 50 to 81; an OB wing in 1943 for 20 more beds; a new 60-bed wing in 1946, and another in 1948. The city's first Premature Center was established in St. Francis Hospital in 1948.

In 1957, a day care center was begun for retarded children, and a medical library was built. In 1959 the new Mother Marianne wing was constructed, and an outpatient psychiatric clinic begun. By 1962 the present bed capacity of 260—and 24 bassinets—was reached. The Home Care Program, described in a guest editorial, was begun at this time.

In 1965 an artificial kidney was installed, an Isotope Unit was begun, an Intensive Care Unit was opened, and a Zeiss operating microscope obtained. It was in this year that affiliation was established with the University of Hawaii School of Medicine and School of Nursing. An Associate Degree Program was initiated with the latter. In 1966 the hospital's School of Nursing graduated its last class, and was discontinued.

The Sisters of St. Francis have continued to take good care of the project they came here from Syracuse, New York, to establish so many years ago. It has thrived under their care. Sister Maureen, the present administrator, and her predecessor, Sister Jolenta, deserve a major share of the credit for its success. It has had sponsorship and guidance from a long list of devoted staff members, too, of whom the late Drs. Paul Withington, Louis Gaspar, and John Felix come to mind.

St. Francis is third in age, and second in size; but it certainly rates first in speed of growth and scope of community services. The JOURNAL is glad to provide a stage on which they can take a well-deserved bow!

We are grateful to Dr. Paul Y. Tamura who, as a guest editor for this issue, solicited the manuscripts, contributing one of his own, and wrote the guest editorial which follows.

# Guest Editorial

## Planning for Future Medical Care

A few years ago St. Francis Hospital took a long view into the future, with the help of a planning firm. What they saw were expansion needs in every department—more personnel and more space, which in turn spelled new buildings and more land.

These are not merely idle dreams or "ambitions" of individuals or a group of people, but a logical way of attempting to anticipate needs of the future and to plan for growth. The anticipated needs are not unique to this hospital. Each institution sees it—in Honolulu, in rural Oahu, in the State, and indeed throughout the country.

Many studies are based on population growth. However, there are indications that patient-visit increase is not proportional to but actually faster than population growth. Add to this Medicare which includes the elderly group with some limits, and the "needy" group, with none. The question thus is not "whether" but "how much" and "how soon."

If growth were only a matter of increased volume, there would not be the deep emotion associated with "progress." Now that the Federal government has expanded its scope of providing medical care, its influence will be felt ever increasingly. Mass-care-at-cost (who defines "cost?") concept, an absolute necessity, must needs result in the sacrifice of something. I wonder what that will be?

We shall see the practice of medicine change. The change will not necessarily be all bad or undesirable. Medical centers and medical schools will flourish with governmental support. The community cannot help but benefit from the presence of an academic institution because of the influence educational and research facilities exert, and the high level of specialized care that becomes available. In view of the size of this State, more than one medical center seems unlikely but not impossible. The existing hospitals will either be incorporated (engulfed?) into this center or will remain community hospitals. Community hospitals are and will continue to be the backbone of medical care facilities, very likely swamped with patients.

Through it all, the doctor will not be able to sit back and just watch this whirlwind of growth and progress. By contributing his time and energies he can become part of it. He will see morphologic or structural studies become more and more ultra mieroscopic. Microbiology will be more chemically oriented. One-day identification of organisms will be rapid, by such instruments as the gas chromatograph. Chemistry will unravel many of the present mysteries of the human body, both normal and diseased states. Studies will become more dynamic. For example, substances will not only be measured, but the rates of formation, accumulation, excretion, or metabolism will be followed by radioisotopes. Exploration of space and ocean bed will bring new knowledge and new problems. Technical advances will develop artificial internal organs to replace worn ones. As we master immunologic responses, we shall ask the reticuloendothelial system to destroy cancer on the one hand and, on the other, to accept transplanted internal organs. Thus will dying become difficult.

The doctor will be busier than he ever was before. The thought may horrify him now, but he may in fact need nurses or receptionists specially trained to screen patients for him. He will use computers that are fed data and spell out studies, diagnoses, and treatment. Automation will allow the patient's laboratory studies to be handled assembly-line fashion, perhaps even without the skin's being punctured or blood's being drawn. Electronic devices to monitor body functions of seriously ill patients are already a reality.

The doctor of the future will be unhappy about more control over his practice of medicine. But this is not new. There is more control today than there was a decade ago. There will be more specialization or, if you will, "ultra-specialization." There will be the ultimate in efficiency and no room for mediocrity.

And what will happen to warm, personalized care for the "Great Society" patients? For the generation that knew such care, the image of the physician will be completely changed; we ask only for mercy. For the generation that never knew it, they will never miss it.

PAUL Y. TAMURA, M.D.

*Lumps and bumps involving the hand should be carefully evaluated—they can be dangerous to life.*

# Hand Tumors: A Review

ANTHONY H. ALTER, M.D., and MERYL H. HABER, M.D., *Honolulu*

• *Hand tumors occur more often than is commonly realized and may pose clinical and therapeutic problems.*

RECENTLY, we studied a series of hand tumors which occurred during a 25-year period in a hospital with an active hand surgery service.[36] It was felt that a comprehensive review of these important lesions might be of benefit to the physician responsible for the diagnosis and treatment of patients with tumorous lesions of the hand.

The incidence of hand tumors from six large series incorporating 4,061 cases[10, 12, 36, 68, 77, 89] is shown in Table 1. The tumors have been organized by tissue of origin and placed into benign and malignant categories for purposes of discussion.

## TUMORS OF THE SKIN

*Squamous Cell Papilloma:* These small, elevated, greyish-tan granular lesions account for 12 per cent of hand tumors. The lesion most often occurs in the middle decades, is seen with equal frequency in men and women and does not show malignant change. It more commonly occurs on the hand than on the fingers.[36]

*Verruca:* A viral etiology has long been known as the cause of these growths. Clinically, these granular, hard, red lesions may be difficult to distinguish from carcinoma. Microscopically, however, their features are characteristic.

*Epidermoid Cyst:* These common lesions account for 24 per cent of epithelial lesions of the hand and for six per cent of the total series. They may be painful and often become secondarily infected. The lesion occurs most often in the middle years, and is more frequently seen in males than females.[29, 32, 75] These cysts are rarely seen in the phalangeal bones.[14, 38]

*Radiation Reaction:* The skin of the hand reacts to excessive radiation in a manner similar to the skin of the rest of the body.[101] This lesion is of significance because patients with it are more prone to develop epidermoid carcinoma. This transition usually occurs many years after the original radiation insult.[98]

*Squamous Cell Carcinoma:* This tumor accounts for the great majority of malignant tumors of the hand. In several large series of hand tumors, the incidence varies from four to 50 per cent. The higher of these figures probably reflects the origin of cases from a specialized hospital.[68] The true incidence of epidermoid carcinoma is probably less

than ten per cent of all hand tumors. In a series of 5,000 carcinomas of the skin from all sites, those distal to the wrist accounted for less than three per cent of the total.[17]

The relationship of squamous carcinoma of the hand to x-rays, other radioactive materials, arsenicals, corrosives, burns, and ointments is well documented.[4, 47, 60, 61, 88, 98]

This tumor is six times as common in men as in women and most often occurs after the fifth decade.[36] It is most often located on the dorsum of the hand, with neither hand showing predominance. Simultaneous tumors on both hands occur in a small percentage of patients.[47, 96] At least a score of patients with squamous cell carcinoma of the nail bed have been reported.[11, 31, 56, 83] Metastasis of skin carcinoma of the hand occurs in from 5.6[36] to 16[86] per cent of patients and may ultimately cause death.

*Basal Cell Carcinoma:* These lesions occur on the hand infrequently,[18] and only one has been reported as arising on the palm.[45] They often ulcerate and distant metastases are rare.

*Skin Appendage Carcinoma:* This tumor is rarely seen on the hand.[79] It is easily distinguished microscopically.

*Malignant Melanoma:* This tumor accounts for less than one per cent of all hand tumors, and accounts for seven per cent of all malignant tumors of the hand.

In several large series of melanomas removed from all sites, 3.2[26] to 11[5] per cent were noted to occur on the hand with a very small percentage of these being subungual.[8, 69, 84] Melanomas of the hand occur more commonly on the dorsum,[8] are slightly more frequent in women and are rare in Negroes.[10] These tumors arise most frequently in the fourth decade. Metastases are most often seen in axillary and cervical lymph nodes.[26]

## TUMORS OF THE SOFT TISSUES

*Ganglion:* These cystic lesions are usually attached to joint spaces or tendon sheaths and are very common. They account for one-quarter of the cases in large series of hand tumors. There is a slightly greater incidence in women[10, 36] and they arise most commonly in the third through sixth decades, but are occasionally present in adolescence.[70] Ganglions of the wrist and hand are more common than those of the fingers.

*Dupuytren's Contracture:* This lesion should not, perhaps, be included in a paper concerned with hand tumors as it is not a true tumor. Clinically, however, Dupuytren's contracture may be difficult to distinguish from a true neoplasm. The incidence of this lesion increases with age, and it is rare before the age of 20.[36] Hueston notes that 20 per cent of persons over 60 may show some degree of contracture.[43] The peak surgical incidence is in the sixth decade.

*Fasciitis or Pseudosarcomatous Fasciitis:* This lesion may be clinically indistinguishable from fibrosarcoma. It most commonly occurs on the forearm,[44] is often multiple, and may involve the superficial or deep fascia.[85] Only isolated cases of its occurrence in the hand have been reported.[93]

*Lipoma:* Lipomas of the hand account for approximately 1.5 per cent of all hand tumors. This tumor occurs more often in the palm than the finger.[6, 9, 34] Pack and Ariel documented the infrequency of lipomas of the hand by noting that only 6, in their series of 390 cases of lipomas from all areas, arose in the hand.[70]

*Leiomyoma:* This is a rare tumor of the hand. Stout reported 16 arising in the hand in a series of 170 soft tissue leiomyomas.[91]

*Giant Cell Tumor of Tendon Sheath:* This lesion accounts for six per cent of hand tumors. Flexor tendons are most commonly involved[63, 73, 90] and the incidence is similar in both sexes. This lesion is most frequently observed in patients between the ages of 30-60 years, and is uncommon in the very young or older age groups.[36]

*Myxoid Cyst or Myxoma:* This infrequent cystic lesion can be characterized by an increased production of hyaluronic acid by fibroblasts in the corium.[48] The terminal portions of the fingers are most commonly affected. Careful examination of these lesions shows no connection with synovium of the joint.[51]

*Fibroma:* This benign tumor accounts for less than one per cent of all hand tumors. Fibromas are slow growing, ovoid, firm, and noninfiltrating, and should be differentiated from juvenile fibromatosis.[92] The latter is seen primarily in the hands of children, has a great growth potential and often recurs.[89]

Another rare variety of a fibrous lesion is the juvenile aponeurotic fibroma of which nine instances have been reported from the hand.[49, 81] This lesion usually occurs in young individuals, shows focal infiltration of surrounding tissues, commonly becomes calcified, and is highly cellular.[7]

*Rare Benign Soft Tissue Tumors:* Two cases of granular cell myoblastoma have been reported in the hand.[36, 42] Dermatofibroma protuberans,[10] benign mesenchyoma,[95] and hamartoma[23] have all been reported as arising in the hand.

*Liposarcoma:* Pack and Pierson reviewed 105 cases of this tumor from all locations and found only one in the hand.[71] Since that time, three additional cases have been reported.[6, 36]

TABLE 1.—*Comparative incidence of hand tumors.*

| | | | | | | | TOTAL | % |
|---|---|---|---|---|---|---|---|---|
| NO. OF CASES IN SERIES | 393 | 437 | 2320 | 464 | 147 | 300 | 4061 | 100 |
| AUTHOR | BOYES[10] | BUTLER[12] | HABER[36] | PACK[88] | POSCH[57] | STACK[80] | | |
| I. SKIN TUMORS: | 45 | 162 | 431 | 315 | 17 | 35 | 1005 | 25 |
| A. *Benign:* | 33 | 53 | 328 | 41 | 6 | 33 | 494 | 12 |
| 1. Squamous cell papilloma | 0 | 10 | 67 | 41 | 0 | 2 | 120 | 3 |
| 2. Fibropapilloma | 0 | 0 | 4 | 0 | 0 | 0 | 4 | |
| 3. Verruca | + | 0 | 91 | 0 | 0 | 0 | 91 | 2 |
| 4. Epidermoid cyst | 33 | 38 | 131 | 0 | 6 | 31 | 239 | 6 |
| 5. Keratoses | + | 5 | 26 | 0 | 0 | 0 | 31 | 1 |
| 6. Radiation Reaction | 0 | 0 | 9 | 0 | 0 | 0 | 9 | |
| B. *Malignant:* | 12 | 109 | 103 | 273 | 11* | 1 | 509 | 13 |
| 1. Squamous cell carcinoma | 12 | 104 | 90 | 232 | | 0 | 438 | 11 |
| 2. Basal cell carcinoma | 0 | 0 | 8 | 12 | | 0 | 22 | 1 |
| 3. Skin appendage carcinoma | 0 | 0 | 2 | | | 0 | | |
| 4. Malignant melanoma | 0 | 5 | 3 | 29 | | 1 | 38 | 1 |
| C. *Metastatic:* | 0 | 0 | 0 | 1 | 0 | 1 | 2 | |
| II. SOFT TISSUE TUMORS: | 308 | 219 | 1170 | 54 | 82 | 211 | 2044 | 50 |
| A. *Benign:* | 307 | 213 | 1159 | 33 | 80 | 211 | 2003 | 49 |
| 1. Ganglion | 205 | 146 | 472 | 0 | 58 | 183 | 1064 | 26 |
| 2. Dupuytren's contracture | + | + | 507 | + | + | 3 | 510 | 13 |
| 3. Pseudosarcomatous fasciitis | 0 | 0 | 3 | 0 | 0 | 0 | 3 | |
| 4. Rheumatoid nodule | 0 | 0 | 3 | 0 | 0 | 4 | 7 | |
| 5. Xanthoma | 0 | 0 | 1 | 0 | 0 | 1 | 2 | |
| 6. Lipoma | 8 | 6 | 32 | 4 | 6 | 5 | 61 | 2 |
| 7. Leiomyoma | 0 | 1 | 1 | 0 | 0 | 0 | 2 | |
| 8. Giant cell tumor tendon sheath | 52 | 32 | 121 | 29 | 12 | 9 | 255 | 6 |
| 9. Myxoma | 0 | 2 | 2 | 0 | 0 | 0 | 4 | |
| 10. Fibroma | 16 | 18 | 12 | 0 | 3 | 4 | 53 | 1 |
| 11. Granular cell myoblastoma | 0 | 0 | 1 | 0 | 0 | 0 | 1 | |
| 12. Dermatofibroma protuberans | 3 | 0 | 2 | 0 | 0 | 0 | 5 | |
| 13. Synovial cyst | 0 | 0 | 0 | 0 | 1 | 0 | 1 | |
| 14. Mucous cyst | 23 | 7 | 2 | 0 | 0 | 2 | 34 | 1 |
| 15. Hamartoma | 0 | 1 | 0 | 0 | 0 | 0 | 1 | |
| B. *Malignant:* | 1 | 6 | 11 | 21 | 2 | 0 | 41 | 1 |
| 1. Liposarcoma | 0 | 0 | 1 | 0 | 0 | 0 | 1 | |
| 2. Fibrosarcoma | 1 | 3 | 6 | 0 | 2 | 0 | 12 | |
| 3. Leiomyosarcoma | 0 | 0 | 1 | 0 | 0 | 0 | 1 | |
| 4. Mesenchynoma | 0 | 0 | 1 | 0 | 0 | 0 | 1 | |
| 5. Dermatofibrosarcoma protuberans | 0 | 0 | 2 | 0 | 0 | 0 | 2 | |
| 6. Sarcoma—type ? | 0 | 1 | 0 | 10 | 0 | 0 | 11 | |
| 7. Synovial sarcoma | 0 | 2 | 0 | 11 | 0 | 0 | 13 | |
| III. VASCULAR TUMORS: | 19 | 32 | 70 | 41 | 18 | 7 | 187 | 5 |
| A. *Benign:* | 19* | 32 | 69 | 40* | 18* | 7 | 185 | 5 |
| 1. Arteriovenous malformations | | 2 | 5 | | | 1 | | |
| 2. Hemangioma | | 26 | 51 | | | 6 | | |
| 3. Lymphangioma | | 0 | 1 | | | 0 | | |
| 4. Glomus | 4 | 4 | 12 | 5 | 8 | 0 | 33 | 1 |
| 5. Lymphatic cyst | | 0 | 0 | | 2 | 0 | 2 | |
| B. *Malignant:* | 0 | 0 | 1 | 1 | 0 | 0 | 2 | |
| 1. Hemangioendothelioma | 0 | 0 | 1 | 0 | 0 | 0 | 1 | |
| 2. Kaposi's sarcoma | 0 | 0 | 0 | 1 | 0 | 0 | 1 | |
| IV. NERVE TUMORS: | 13 | 8 | 611 | 20 | 5 | 8 | 665 | 16 |
| A. *Benign—Neurilemmoma:* | 13 | 7 | 607 | 12 | 5 | 8 | 652 | 16 |
| B. *Malignant—Neurofibrosarcoma:* | 0 | 1 | 4 | 8 | 0 | 0 | 13 | |
| V. BONE TUMORS: | 8 | 12 | 38 | 14 | 6 | 15 | 93 | 2 |
| A. *Benign:* | 7 | 11 | 36 | 11 | 5* | 15 | 85 | 2 |
| 1. Osteochondroma | 2 | 3 | 7 | 0 | | 9 | 21 | 1 |
| 2. Enchondroma | 5 | 7 | 25 | 11 | | 6 | 54 | 1 |
| 3. Giant cell tumor of bone | 0 | 0 | 2 | 0 | | 0 | 2 | |
| 4. Aneurysmal bone cyst | 0 | 0 | 2 | 0 | | 0 | 2 | |
| 5. Osteoid osteoma | 0 | 1 | 0 | 0 | | 0 | 1 | |
| B. *Malignant:* | 1 | 0 | 0 | 3 | 1 | 0 | 5 | |
| C. *Metastatic:* | 0 | 1 | 2 | 0 | 0 | 0 | 3 | |
| IV. PSEUDOTUMORS: | 0 | 4 | 0 | 20 | 19 | 24 | 67 | |

+ — Specifically excluded from series.
* — Unclassified as to morphologic type.

*Fibrosarcoma:* This malignancy comprises two per cent of the malignant tumors of the hand. The tumor is a slowly growing invasive lesion. There is no sexual preponderance and it is seen most frequently between 40-50 years of age.[13, 33, 37] It is the most common of the soft tissue sarcomas of the hand. Various reviews of fibrosarcoma note that they are localized to the hand in a frequency of one case in 13[3]-80[64] patients, and they may show myxomatous variation.[52]

*Rhabdomyosarcoma:* Potenza and Winslow recorded twelve tumors of this type from the hand in a literature review.[78] In a recent paper, Lindschieid, *et al.* added five more cases in a review of 87 such tumors.[58] Horn and Enterline also note one case.[39] This tumor may appear in a variety of microscopic forms and offers a poor prognosis.

*Synovial Sarcoma:* Synovial sarcoma comprises less than two per cent of hand malignancies. Approximately ten per cent of all synovial sarcomas arise in the hand and wrist.[1, 100] The average age is 30 years and most patients are less than 40. Distant metastases are common and the course is usually fatal.

*Other Rare Sarcomas:* At least one leiomysarcoma[36] and two malignant mesenchyomas of the hand have been recorded.[36, 54] Dermatofibrosarcoma protuberans has rarely been seen.[36, 72, 97] A group of sarcomas which cannot be classified accounts for less than two per cent of all hand malignancies.

## TUMORS OF VASCULAR ORIGIN

*Hemangioma:* These lesions account for two per cent of hand tumors. Clinically, they rarely produce symptoms, present infrequent cosmetic problems, and may regress without treatment. For these reasons, hemangiomas are often not removed and thus their true incidence is difficult to ascertain.[67, 102] Young patients more commonly present for surgical consideration.

*Glomus Tumor:* Approximately one per cent of patients operated on for tumor of the hand have glomangiomas. Some reports note a higher incidence in the female[36, 41, 65, 82] while Otley,[66] in his review, records a greater incidence in males. Subungual location of this tumor accounts for one-fourth of cases arising in the hand, and the majority of these are in women.[94] Most cases are not discovered until adulthood, but Kohout and Stout recorded 22 glomus tumors in the hands of children.[53] Multiple glomangiomas have been reported.[94]

*Rare Vascular Tumors:* Arteriovenous malformation occurring in the hand is usually secondary to trauma,[22, 24, 27, 40] but may be congenital. Lymphangiomas occur, and may be multiple.[67] Malignant vascular tumors such as hemangioendothelioma and Kaposi's sarcoma have been reported but are extremely rare.[94]

## TUMORS OF NERVE SHEATH ORIGIN

*Neurilemmoma or Neuroma:* This tumor often occurs in the hand and is commonly associated with trauma. The incidence varies greatly in different series, from 1.5[12] to 26[36] per cent. This variance is probably related to the incidence of trauma to the hand. Males are more often involved than females and the peak incidence is in the fourth decade in both sexes.[36]

*Neurofibrosarcoma:* This tumor comprises two per cent of malignancies of the hand. This sarcoma has been known to develop in benign neurofibromas of the hand in patients with von Recklinghausen's neurofibromatosis.[70]

## TUMORS OF BONE

*Osteochondroma or Osteocartilaginous Exostosis:* This tumor accounts for one-fifth of bone tumors of the hand. Involvement of the metacarpal bones of the hand in multiple osteochondromatosis has been noted.[25, 46]

*Enchondroma:* This lesion is very common and accounts for approximately one-half of all bone tumors of the hand. Enchondromas occur most often in the proximal phalanges followed in frequency by the metacarpals.[87] They occur with equal frequency in both sexes and may be multiple.[25] An extremely rare form of this tumor has been reported by Lichtenstein and Goldman.[57] They noted eight patients having an enchondroma entirely within soft tissues without attachment to bone.

*Rare Benign Bone Tumors:* Approximately three per cent of all cases of giant cell tumors of bone arise in the hand.[21] Isolated case reports of tumors of bones of the hand include aneurysmal bone cyst,[36, 62, 99] osteoid osteoma,[15, 30, 76] solitary bone cyst,[20, 74] hemangioma,[94, 99] and fibrous dysplasia.[55] Mangini recently reported a chondroblastoma in the capitate bone.[59]

*Osteogenic Sarcoma:* Carroll recorded ten cases of this tumor occurring in bones of the hand in a general review of osteosarcoma.[16] To this Coley, in 1960, added seven patients in a review of 985 primary osteogenic sarcomas from all sites.[19] The phalangeal bones are more often involved than the other bones of the hand.

*Chondrosarcoma:* Gottschalk *et al.,* in 1963, recorded a total of seventeen cases occurring in the hand in a review.[35] This hand tumor is most typically seen in middle age adults. There is no

sexual preponderance. The localization is similar to osteogenic sarcoma.

*Ewing's Sarcoma:* Isolated cases of this tumor in the hand have been noted.[10, 18]

*Metastases to Bone:* Tumors metastatic to the bones of the hand may often be discovered before the primary.[2] They originate in a wide variety of organs, with lung the most common primary site. Most of the patients are in the older age groups and males outnumber females. Any bone in the hand may be involved and multiple hand bone involvement has been recorded.[28, 50]

## SUMMARY

Tumorous lesions of the hand present a wide variety of clinical and morphological variation. Tumors arising from the skin account for one-quarter of hand tumors, those from the soft tissues for one-half, vascular tumors account for five per cent, nerve sheath tumors for 16 per cent, and primary bone neoplasms for two per cent. Malignant tumors account for 14 per cent of all hand tumors.

Squamous cell carcinoma is the most common malignant tumor of the hand and comprises 78 per cent of all malignancies. This tumor is often associated with high doses of irradiation and, if left untreated, may result in death. Other malignant neoplasms of the hand are uncommon and a wide variety have been noted.

Benign tumors comprise 86 per cent of hand tumors. These lesions vary greatly as to morphologic type, ganglions and neurilemmomas the most common.

2260 Liliha St., 96817

## REFERENCES

1. Ariel, I. M., and Pack, J. T.: Treatment of tumors of synovial tissue. In Treatment of cancer and allied diseases: vol. VIII, tumors of soft somatic tissues and bones, 2d Edition, New York, Harper & Row, 1964.
2. Bell, J. L., and Mason, M. L.: Metastatic tumors of the hand: report of two cases, Quart. Bull. Northwest. Univ. Med. Sch. 27:114-116 (Summer) 1953.
3. Bick, E. M.: Fibrosarcoma of the extremities, Ann. Surg. 101: 759-765 (Feb.) 1935.
4. Bick, E. M.: Primary carcinoma of the extremities, Ann. Surg. 103:410-414 (Mar.) 1936.
5. Bickel, W. H., Myerding, H. W., and Broders, A. C.: Melanoepithelioma (melanosarcoma, melanocarcinoma and malignant melanoma) of extremities, Surg. Gynec. Obstet. 76:570-576 (May) 1943.
6. Booher, R. J.: Lipoblastic tumors of the hands and feet, J. Bone Joint Surg. 47A:727-740 (June) 1965.
7. Booher, R. J., and McPeak, C. J.: Juvenile aponeurotic Fibromas, Surgery 46:924-931 (Nov.) 1959.
8. Booher, R. J., and Pack, G. T.: Malignant melanoma of the feet and hands, Surgery 42:1085-1121 (Dec.) 1957.
9. Bosch, D. T., and Bernhard, W. G.: Lipoma of the palm, Amer. J. Clin. Path. 20:262 (Mar.) 1950.
10. Boyes, J. H.: Bunnell's surgery of the hand, J. B. Lippincott Co., Phil., 1964.
11. Branson, F. W., Eschner, E. G., Sanes, S., and Milkey, G.: Secondary carcinoma of the phalanges, Radiology 57:864-867 (Dec.) 1951.
12. Butler, E. D., Hamill, J. P., Seipel, R. S., and DeLorimier, A. A.: Tumors of the hand, a ten-year survey and report of 437 cases, Amer. J. Surg. 100:293-302 (Aug.) 1960.
13. Carrol, G. A., and Martin, T. M.: Fibrosarcoma of the extremities, Surg. Clin. N. Amer. 24:1220-1227 (Oct.) 1944.
14. Carroll, R. E.: Epidermoid (epithelial) cyst of the hand skeleton, Amer. J. Surg. 85:327-334 (Mar.) 1953.
15. Carroll, R. E.: Osteoid osteoma in the hand, J. Bone Joint Surg. 35A:888-893 (Oct.) 1953.
16. Carroll, R. E.: Osteogenic sarcoma in the hand, J. Bone Joint Surg. 39A:325-331 (Apr.) 1957.
17. Clarke, H. M.: Primary carcinoma of the extremity, Surg. Gynec. Obstet. 79:669-672 (Dec.) 1944.
18. Clifford, R. H., and Kelly, A. P.: Primary malignant tumors of the hand, Plast. Reconstr. Surg. 15:227-232 (Mar.) 1955.
19. Coley, B. L.: Neoplasms of bone, Second Edition, Hoeber, New York, 1960.
20. Coley, B. L., and Higinbotham, N. L.: Solitary bone cyst, Ann. Surg. 99:432-448 (Mar.) 1934.
21. Compere, E., Bowman, J., and Alter, A.: Giant cell tumor of bone; a presentation of 28 new cases with a review of the literature. To be published in book or journal.
22. Coursley, G., Ivins, G. C., and Barker, N. W.: Congenital arterio-venous fistula in the extremities, Angiology 7:201-217 (June) 1956.
23. Coventry, M. B., Woolner, L. B., and Anderson, M. L.: Hamartoma of the hand; a case report, Proc. Mayo Clin. 24:587-589 (Nov.) 1949.
24. Curtis, R. M.: Congenital arterio-venus fistulae of the hand, J. Bone Joint Surg. 35A:917 (Oct.) 1953.
25. Dahlin, D. C.: Bone tumors: general aspects and an analysis of 2,276 cases, Charles C. Thomas, Springfield, Ill., 1957.
26. Das Gupta, T., and McNeer, G.: The incidence of metastases to accessible lymph nodes from melanoma of the trunk and extremities: its therapeutic significance, Cancer 17:897-911 (July) 1964.
27. David, J. C.: Aneurysms of the hand, Arch. Surg. 33:267-275 (Aug.) 1936.
28. DePass, S. W., Roswit, B., and Unger, S. M.: Metastatic carcinoma in the bones of the hand: a report of two cases, Amer. J. Roentg., 79:643-644 (Apr.) 1958.
29. Dolce, F. A., and Clark, R. L.: Epithelial cysts (of the hand), N.Y. J. Med. 44:2358-2359 (Nov.) 1944.
30. Dunitz, N. L., Lipscomb, P. R., and Ivins, J. C.: Osteoid osteoma of the hand and wrist, Amer. J. Surg. 94:65-69 (July) 1957.
31. Ellis, V. H.: Squamous cell carcinoma of the nail bed, J. Bone joint Surg. 30B:656-658 (Nov.) 1948.
32. Fuelner, R. C., and Marks, J. L.: Epidermoid (epithelial) cyst of the hand, Amer. J. Roentg. 79:645-647 (Apr.) 1958.
33. Gentele, H.: Malignant fibroblastic tumors of skin: clinical and pathological-anatomical studies of 129 cases of malignant fibroblastic tumors from cutaneous and subcutaneous layers observed at radiumhemmet during period of 1927-1947, Acta., Dermatovener. (Stockholm) Supp. 127:1-180, 1951.
34. Geschickter, C. F.: Benign lipomas and the lipomatoses. Treatment of cancer and allied diseases: vol. VIII, tumors of soft somatic tissues and bones, Second Edition, Harper & Row, 1964.
35. Gottschalk, R. G., and Smith, R. T.: Chondrosarcoma of the hand: report of a case with radioactive sulfur studies and review of the literature, J. Bone Joint Surg., 45A:141-150 (Jan.) 1963.
36. Haber, M. H., Alter, A. H., and Wheelock, M. C.: Tumors of the hand, Surg. Gynec. Obstet. 121:1073-1080 (Nov.) 1965.
37. Heller, E. L., and Sieber, W. K.: Fibrosarcoma: a clinical and pathological study of 60 cases, Surgery 27:539-545 (Apr.) 1950.
38. Hinrichs, R. A.: Epidermoid cyst of the terminal phalanx of the hand, JAMA 194:1253-1254 (Dec.) 1965.
39. Horn, R. C., and Enterline, H. T.: Rhabdomyosarcoma: a clinicopathological study and classification of 39 cases, Cancer 11:181-199 (Jan.) 1958.
40. Horton, B. T., and Ghormley, R. K.: Congenital arteriovenous fistulas of the extremities "visualized" by arteriography, Surg. Gynec. Obstet. 60:978-983 (May) 1935.
41. Horton, C., Maguire, C., and Georgiado, N.: Glomus tumors: an analysis of 25 cases, Arch. Surg. 71:712-716 (Nov.) 1955.
42. Howe, C. W., and Warren, S.: Myoblastoma, Surgery 16:319-347 (Sept.) 1944.
43. Hueston, J. T.: Dupuytren's contracture, E. & S. Livingstone Ltd., London, 1963.
44. Hutter, R. V. P., Stewart, F. W., and Foote, F. W., Jr.: Fasciitis, Cancer 15:992-1003 (Sept.-Oct.) 1962.
45. Hyman, A. B., and Barsky, A. J.: Basal cell epithelioma of the palm, Arch. Derm. 92:571-573 (Nov.) 1965.
46. Jaffe, H. L.: Tumors and tumorous conditions of the bones and joints, Lea Febiger, Philadelphia, 1958.
47. Johnson, R. E., and Ackerman, L. V.: Epidermoid carcinoma of the hand, Cancer 3:657-666 (July) 1950.
48. Johnson, W. C., Graham, J. H., and Helwig, E. B.: Cutaneous myxoid cyst, JAMA 191:15 (Jan.) 1965.
49. Keasby, L. E.: Juvenile aponeurotic fibroma (calcifying fibroma): a distinctive tumor arising in the palms and soles of young children, Cancer 6:338-346 (Mar.) 1953.
50. Kerin, R.: Metastatic tumors of the hand, J. Bone Joint Surg. 40A:263-278 (Apr.) 1958.
51. Kingery, F. A. J.: Myxoid cysts, JAMA 194:1239 (Dec.) 1965.
52. Kleinberg, S.: Soft tissue sarcoma of the hand, Bull. Hosp. Joint Dis. 9:81-85 (Apr.) 1948.

53. Kohout, E., and Stout, A. P.: The glomus tumor in children, Cancer 14:555-556 (May-June) 1961.
54. Lawrence, W., Jegge, G., and Foote, F. W.: Embryonal rhabdomyosarcoma: a clinicopathological study, Cancer 17:361-376 (Mar.) 1964.
55. Lehman, W. B., and Ariel, I. M.: Uncommon primary tumors of bone: treatment of cancer and allied diseases: vol. VIII. Tumors of soft somatic tissues and bones, Second Edition, Harper & Row, 1964.
56. Levine, J., and Lise, J. R.: Primary carcinoma of the nail, Arch. Surg. 38:107-112 (Jan.) 1939.
57. Lichtenstein, L., and Goldman, R. C.: Cartilage tumors in soft tissues: particularly in the hand and foot, Cancer 17:1203-1208 (Sept.) 1964.
58. Lindscheid, R. L., Soule, E. H., and Henderson, E. D.: Pleomorphic rhabdomyosarcomata of the extremities and limb girdles: a clinicopathological study, J. Bone Joint Surg. 47A: 715-725 (June) 1965.
59. Mangini, U.: Benign chondroblastoma localized in the capitate bone: a case report, Bull. Hosp. Joint Dis. 25:50-56 (Apr.) 1964.
60. Mason, M. L.: Carcinoma of hand, Arch. Surg., Part II, 18: 2107-2158 (May) 1929.
61. Mason, M. L.: Carcinoma of hands and feet, Surgery 5:27-46 (Jan.) 1939.
62. Mason, M. L., and Wheelock, M. C.: Aneurysmal bone cyst of the hand, Quart. Bull. Northwest. Univ. Med. Sch. 32:268-271 (Fall) 1958.
63. Mason, M. L., and Woolston, W. H.: Isolated giant cell xanthomic tumors of the fingers and hands, Arch. Surg. 15: 499-529 (Oct.) 1927.
64. Meyerding, H. W., Broders, A. C., and Hargrove, H. L.: Clinical aspects of fibrosarcoma of the extremities, Surg. Gynec. Obstet. 62:1010-1019 (June) 1936.
65. Murray, M. R., and Stout, A. P.: The glomus tumor: investigation of its distribution and behavior, and identity of its "epitheliod" cell, Amer. J. Path. 18:183-203 (Mar.) 1942.
66. Ottley, C. M.: Glomus tumor, Brit. J. Surg. 29:387-391 (Apr.) 1942.
67. Oughterson, A. W., and Tennant, R.: Angiomatous tumors of hands and feet, Surgery 5:73-100 (Jan.) 1939.
68. Pack, G. T.: Symposium: tumors of the hands and feet, Surgery 5:1-26 (Jan.) 1939.
69. Pack, G. T., and Adair, F. E.: Subungual melanoma, Surgery 5:47-72 (Jan.) 1939.
70. Pack, G. T., and Ariel, I. M.: Treatment of cancer and allied diseases: vol. VIII. Tumors of soft somatic tissues and bones, Second Edition, Harper & Row, 1964.
71. Pack, G. T., and Pierson, J. C.: Liposarcoma: a study of 105 cases, Surgery 36:687-712 (Oct.) 1954.
72. Pack, G. T., and Tabah, E. J.: Dermatofibrosarcoma protuberans: report of 39 cases, Arch. Surg., 62:391-411 (Mar.) 1951.
73. Phalen, G. S., McCormack, L. J., and Gazale, W. J.: Giant cell tumor of tendon sheath (benign synovioma) in the hand, evaluation of 56 cases, Clin. Orthop. 15:140-151 (Winter) 1959.
74. Platt, H.: Cysts of the long bones of the hand and foot, Brit. J. Surg. 18:20-37, 1930.
75. Pohlman, H. F., and Wachstein, M.: Epidermoid (squamous epithelial) bone cysts of the phalanx, Ann. Surg. 119:148-154 (Jan.) 1944.
76. Ponseti, I., and Barta, C. K.: Osteoid osteoma, J. Bone Joint Surg. 29:767-776 (July) 1947.
77. Posch, J. L.: Tumors of the hand, J. Bone Joint Surg. 38A: 517-540 (June) 1956.
78. Potenza, A., and Winslow, D.: Rhabdomyosarcoma of the hand, J. Bone Joint Surg. 43A:700-708 (July) 1961.
79. Potter, C. M.: Pleomorphic tumor of sweat gland in the hand, J. Bone Joint Surg. 39B:102-105 (Feb.) 1957.
80. Prior, J. T., and Sisson, B. J.: Dermal and fascial fibromatosis, Ann. Surg. 139:453-467 (Apr.) 1954.
81. Rios-Dalenz, J. L., Kim, J. S., and McDowell, F. W.: The so-called "juvenile aponeurotic fibroma," Amer. J. Cl. Path. 44:632-635 (Dec.) 1965.
82. Riveros, M., and Pack, G. T.: The glomus tumor: report of 20 cases, Ann. Surg. 133:394-400 (Mar.) 1951.
83. Russell, L. W.: Primary carcinoma of the nail, JAMA 144: 19-20 (Sept.) 1950.
84. Scannell, R. C.: Subungual melanoma, Amer. J. Surg. 53:163-167 (July) 1941.
85. Schreiber, M. M., Shapiro, S. I., and Sampsel, J.: Pseudosarcomatous fibromatosis (fasciitis), Arch. Derm. 92:661-665 (Dec.) 1965.
86. Schrek, R.: Cutaneous carcinoma III: carcinoma statistical analysis with respect to site, sex and pre-existing scars, Arch. Path. 31:434-448 (Apr.) 1941.
87. Shellito, J. G., and Dockerty, M. B.: Cartilaginous tumors of hand, Surg. Gynec. Obstet. 86:465-472 (Apr.) 1948.
88. Sommers, S. C., and McManus, R. G.: Multiple arsenical cancers of the skin and internal organs, Cancer 6:347-359 (Mar.) 1953.
89. Stack, H. G.: Tumors of the hand, Brit. Med. J. 517:919-922 (Mar.) 1960.
90. Stevenson, T. W.: Xanthoma and giant cell tumor of the hand, Plast. Reconstr. Surg. 5:75-87 (Jan.) 1950.
91. Stout, A. P.: Solitary cutaneous and subcutaneous leiomyoma, Amer. J. Cancer 29:435-469 (Mar.) 1937.
92. Stout, A. P.: Juvenile fibromatosis, Cancer 7:953-978 (Sept.) 1954.
93. Stout, A. P.: Pseudosarcomatous fasciitis in children, Cancer 14:1216-1222 (Nov.-Dec.) 1961.
94. Stout, A. P.: Tumors of the blood and lymphatic vessels: treatment of cancer and allied diseases: vol. VIII, Tumors of soft somatic tissues and bones, Second Edition, Harper & Row, 1964.
95. Stout, A. P.: Mesenchymoma, the mixed tumor of mesenchymal derivatives, Ann. Surg. 127:278-290 (Feb.) 1948.
96. Taylor, G. W., Nathanson, I. T., and Shaw, D. T.: Epidermoid carcinoma of the extremities with reference to lymph node involvement, Ann. Surg. 113:268-275 (Feb.) 1941.
97. Taylor, H. B., and Helwig, E. B.: Dermatofibrosarcoma protuberans: a study of 115 cases, Cancer 15:717-725 (July-Aug.) 1962.
98. Teloh, H. A., Mason, M. L., and Wheelock, M. C.: A histopathologic study of radiation injuries of the skin, Surg. Gynec, Obstet. 90:335-348 (Mar.) 1950.
99. Thomas, A.: Vascular tumors of bone: a pathological-clinical study of 27 cases, Surg. Gynec. Obstet. 74:777-795 (Apr.) 1942.
100. Tillotson, J. F., McDonald, J. R., and Janes, J. M.: Synovial sarcomata, J. Bone Joint Surg. 33A:459-473 (Apr.) 1951.
101. Warren, S.: Effects of radiation on normal tissues, XIII. Effects on the skin, Arch. Path. 35:340-347 (Jan.) 1943.
102. Weisman, P. A.: Blood vessel tumors of the hand, Plastic Reconstr. Surg. 23:175-186 (Feb.) 1959.

# Cystadenofibroma of the Ovary

## Report of a Case

KUNIO MIYAZAWA, M.D., and FREDERICK S. F. LEE, M.D., *Honolulu*

• *Ovarian cystadenofibromas are relatively rare. The purpose of this article is to emphasize the existence, and the significance of making a diagnosis, of this benign ovarian tumor, which grossly resembles a malignancy.*

THE CYSTADENOFIBROMA of the ovary may be easily mistaken for malignancy on laparotomy because it has characteristics similar to those of a malignant ovarian tumor.

### CASE REPORT

This 59-year-old single, nulliparous Portuguese woman was admitted to St. Francis Hospital on November 28 for progressive pelvic discomfort of six months' duration with a concurrent weight loss of 15 lbs. One month prior to admission she noted constant lower abdominal pain, aggravated by defecation. There was increase in facial hypertrichosis, nausea, and symptoms of urinary frequency and urgency. The patient denied a history of vaginal bleeding, tarry stools, or hematemesis. Menopause was at the age of 52. She had taken probenecid (Benemid) for gouty arthritis for the past three years and chlordiazepoxide HCl (Librium), 10 mg b.i.d. for the past week.

Past history was noncontributory except for an office hemorrhoidectomy.

Family history essentially negative except for a diabetic mother.

Physical examination on admission revealed her weight to be 139 lbs, height 5 ft; blood pressure 120/68, pulse 96/min, respirations 24/min, temperature 99.4°F. She was a well-developed, slightly obese woman in no distress. Slight hirsutism was noted over her face and extremities, along with rather dry skin.

The major significant physical finding was an irregular, firm, movable abdominal mass, arising out of the pelvis to midway between the pubis and the umbilicus; it was somewhat tender at the right upper pole. There were no signs suggestive of ascites. Pelvic examination revealed atrophic external genitalia, a rigid hymeneal ring, and an atrophic, nontender cervix. The uterine fundus was poorly delineated because of obesity but was thought to be irregular. A multinodular mass was palpable in the right adnexa. The culdesac was free of nodularity. Rectal examination confirmed the pelvic findings.

Laboratory Examination: Hgb was 11.2 gm, PCV 36%, RBC 4.0, WBC 9,700, normal differential. Platelets appeared adequate. Urinalysis, negative albumin and sugar, 0-1 WBC, occ. RBC/hpf. Fasting blood sugar was 91 mg%; uric acid 5.6 mg%; 17-ketosteroids 5 mg/24-hour urine specimen. Guaiac examination of the stool for occult blood was negative. Papanicolaou smear was Class I with a maturation index of 0-100-0. Electrocardiogram was within normal limits.

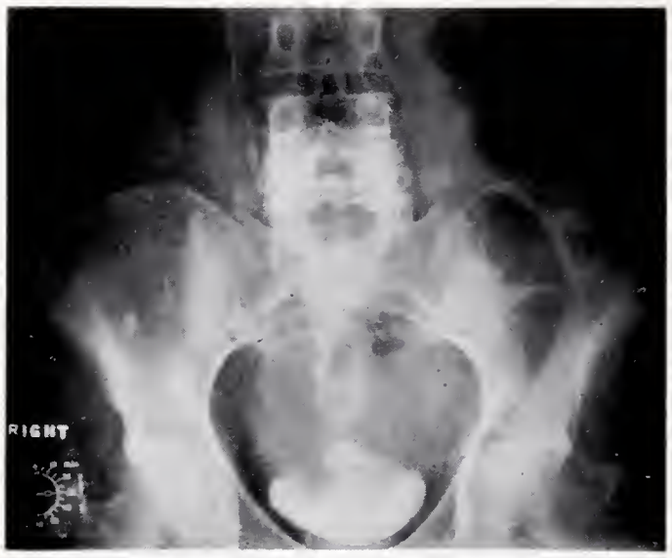



FIG. 1.—*Intravenous pyelogram revealing an extrinsic mass compressing the bladder dome.*

X-ray Examination: Chest x-ray revealed slight cardiomegaly and tortuosity of the aorta. Intravenous pyelogram revealed an extrinsic mass compressing the bladder dome (Fig. 1). Proctosigmoidoscopy was unremarkable except for cryptitis. Barium enema showed fixation of the distal portion of the rectosigmoid in the midline, with extrinsic compression up to the level of the sacral promontory (Fig. 2A & B). Gall bladder series was within normal limits.

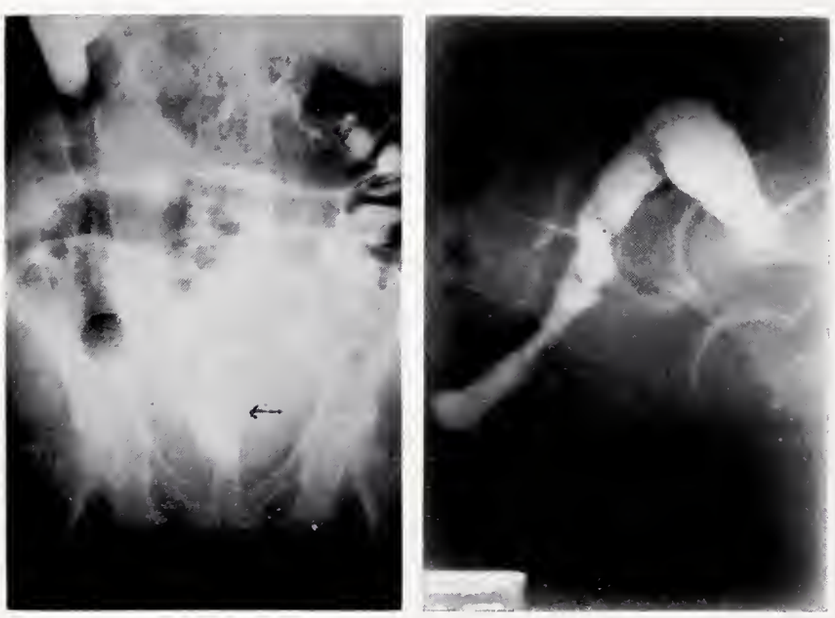
Operative Procedure: Upon entering the abdomen, a multicystic left ovarian mass, approximately 13 cm, was found, with multiple adhesions to the rectosigmoid and ascending portion of the ileocecal junction. The uterus was small and atrophic with multiple small fibroids. The right ovary appeared 1½ times normal size, with multiple firm nodular cystic structures on the external surface. The tubes were normal, and intra-abdominal exploration was normal. Tissue was obtained from the left ovarian tumor for frozen section studies and reported as benign. Bilateral salpingo-oophorectomy, total abdominal hysterectomy, and incidental appendectomy were performed. The patient received two units of blood. Her postoperative course was uneventful and she was discharged on the seventh postoperative day in good condition.

Pathologic Findings: Gross examination (Fig. 3) revealed the left ovarian tumor to be multiloculated, cystic, 15 cm in its largest diameter, with minute papillary projections on the grey-white smooth external surface, and on section contained hemorrhagic and albuminous fluid with dense masses of yellow-white firm tissue separating the cystic spaces. The largest intracystic mass was 8 cm and some were hemorrhagic and necrotic. The right ovary with the multinodular cystic area was 5 cm in its greatest diameter.

Microscopic examination (Fig. 4) revealed numerous mucin-filled cystic spaces lined with single or multiple layered cuboidal epithelium embedded in whorled fibrous stroma. Glandular elements were distorted by proliferative fibrous stroma. There were areas of hemorrhagic necrosis. A small amount of identical ovarian tissue was visible. No malignancy was detected. The uterus weighed 54 gm, with leiomyomata, and endometrium of the senile nonsecretory type. Gross and microscopic findings of the ovaries were compatible with cystadenofibroma.

## DISCUSSION

Cystadenofibroma of the ovary was first described in English literature by Wolfe[1] in 1927 as two rare ovarian tumors. He reported this tumor as a complex tumor of the benign type in which epithelial and stromal elements simultaneously multiply. The tumor is usually a large, very firm, irregular, nodular growth, the cut surface of which is often



FIGS. 2A AND 2B.—*Two views showing fixation of the distal portion of the rectosigmoid in the midline, with extrinsic compression up to the level of the sacral promontory.*

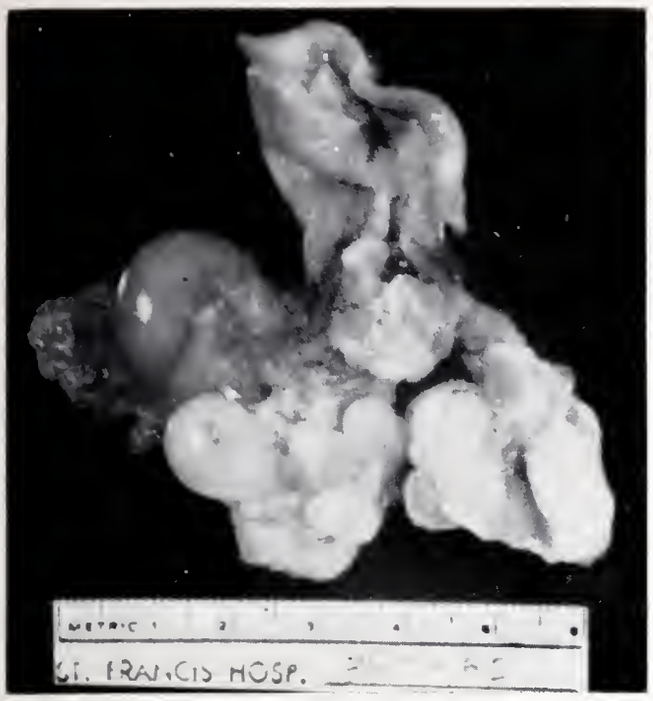



FIG. 3.—*Cross section of multiloculated left ovarian tumor.*

porous or sieve-like, sometimes sufficiently cystic. It is commonly found in older women. The smoothly lined cystic space in a firm, nodular fibrous tumor on gross section is of diagnostic aid. Microscopically, glands and cysts of various forms, in groups or scattered in connective tissue, lined mostly with flattened epithelium, are seen.

Like serous cystadenoma, cystadenofibroma arises from the germinal epithelium of the ovary. This undergoes invagination, with the formation of long cleft-like tubules covered with fibrous tissue. If the invagination becomes cystic and reaches large size, the tumor is called a cystadenofibroma, and is usually partially cystic and partially solid in various proportions.

This relatively uncommon type of ovarian tumor has received only scant attention in the literature. In 1942 Scott[2] reported 13 cases of such a tumor among 26,000 gynecological cases over a period

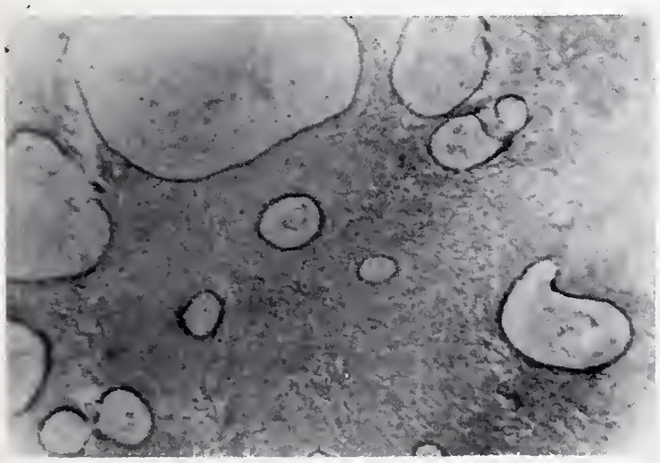


FIG. 4.—*Numerous mucin-filled cystic spaces lined with single- or multiple-layered cuboidal epithelium, embedded in whorled fibrous stroma.*

of 20 years. Among these cases, myoma uteri was found in six, and in five abnormal bleeding was observed. Pain was the most common, persistent complaint. Of the patients, 93.5 per cent were 40 years of age or older. No malignancy was found.

In 1959, McNulty[3] reported 25 patients with serous cystadenofibroma, 12 of whom were found to have unusual endometrial activity suggesting estrogenic influences, seven with endometrial hyperplasia, four with endometrial carcinoma, and one with endometrial carcinosarcoma. Also, it was suggested but not proved that at some phase of development, these tumors possess an estrogen-secreting property. Not infrequently, they have been associated with a hormonally active component. This has been suggested, as well, with other "nonfunctioning" ovarian tumors, such as cystadenoma, Brenner tumor, dysgerminoma, and primary and secondary ovarian cancer by several authors in recent literature.[4, 5]

Although this patient did not have any unusual endometrial activity suggesting estrogenic influences, it is of interest that the tumor was associated with uterine fibroid. At laparotomy, this tumor was thought to be malignant at first, but the frozen section of the external papillary excrescences was reported as benign. This tumor is usually classified only after pathologic studies. Its irregular surface and hard consistency often suggest malignancy to the operator. Thus, it is important to know of the existence of this benign type of tumor in order to interpret ovarian masses.

## SUMMARY

A case of bilateral ovarian cystadenofibroma has been reported and characteristic features of this tumor have been reviewed and discussed. It has been emphasized that the existence of this benign tumor should be kept in mind as a differential diagnosis of an ovarian tumor which appears grossly malignant.

## ACKNOWLEDGMENT

Sincere thanks are expressed to Dr. Stanley M. Saiki, Chief of the Department of Obstetrics and Gynecology, and Dr. Young Ki Paik, Associate Pathologist, St. Francis Hospital, for their continuous guidance and assistance in the accomplishment of this article. ■

421 Prospect St., 96813

## REFERENCES

1. Wolfe, S. A.: Two rare ovarian tumors. Amer. J. Obstet. Gynec. 13:16 (June) 1927.
2. Scott, R. B.: Serous adenofibroma and cystadenofibromas of the ovary. Amer. J. Obstet. Gynec. 43:733 (Jan.) 1942.
3. McNulty, J. R.: The ovarian serous cystadenofibroma: a report of 25 cases. Amer. J. Obstet. Gynec. 77:1338 (June) 1959.
4. Plotz, E. J.: Steroid synthesis in cystadenocarcinoma of the ovaries. Amer. J. Obstet. Gynec. 94:189 (Jan.) 1966.
5. Grady, H. G., and Smith, D. E.: The ovary. pp. 222-224, The Williams & Wilkins Company, 1963.

*Respiratory and feeding difficulties in infants should call to mind anomalies of the aortic arch.*

# Complete Vascular Ring As a Cause of Esophageal and Tracheal Compression

## Review of the Literature and Report of a Case

MANUEL A. ABUNDO, JR., M.D., and RICHARD K. S. PANG, M.D., *Honolulu*

*Complete vascular ring is one of the anomalous developments of the aortic arch. The other arterial malformations for which surgery is done to relieve esophageal and tracheal compression include right aortic arch with a left ligamentum arteriosum, anomalous innominate artery, anomalous left common carotid artery, and aberrant right subclavian artery.*

THIS PAPER is concerned with double aortic arch or so-called complete vascular ring. In this anomaly, there is persistence of the right and left fourth branchial arches, growing equally, making a ring of aortic tissue surrounding the trachea and esophagus. It becomes clinically significant when it compresses such mediastinal structures, interfering with respiration and swallowing (dysphagia lusoria) (Fig. 1).

Complete vascular ring is a rare entity. Less than 100 cases have been reported in the literature. The first description of complete vascular ring was first given by Hommel in 1737. Symptomatic double aortic arch was described by Siebold in 1836. The surgical significance was noted by Abbott in 1932. Gross in 1945 performed and published the first successful division of the anterior arch in a case of complete vascular ring with relief of symptoms. Abbott describes five cases of double aortic arch in 1,000 cases of congenital heart disease. Mustard noted three cases of complete vascular ring in 3,000 autopsies. Blalock recorded one case of double aortic arch in more than 600 subclavian pulmonary anastomoses for Tetralogy of Fallot.

### REPORT OF CASE

A three-month-old male infant was admitted to the hospital because of stridor and difficulty with feeding. These were noted at the age of one week. A week before admission, his condition worsened and he became cyanotic at times, choking when he was fed. He was delivered as a full-term infant with a birth weight of 5 lbs. At the age of six weeks, he was admitted to the hospital in acute respiratory distress and with subcostal retraction. The family physician felt that the infant had laryngotracheobronchitis, and antibiotic therapy was begun and tracheostomy performed. However, tracheostomy did not relieve the stridor.

He was followed carefully in the family doctor's clinic and later in the hospital. He was noted to be gaining very little weight, and a week before his last admission, he was given blood transfusions and oral iron medication because of anemia. His hemoglobin rose from 6.4 gms to 11.2 gms. Wheezing and stridor, especially after eating, seemed to get worse. A surgical consultation was then sought.

Physical examination revealed a three-month-old infant with a tracheostomy tube in place. The infant was noncyanotic and assumed an opisthotonic position, and manifested a crowing, noisy type of respiration. Subcostal retraction was noted. Both lung fields revealed rales and generalized rhonchi. The heart was not enlarged; no murmur was noted; there was slight tachycardia, but no precordial heave. Abdomen examination revealed no organomegaly and bowel sounds were normal. Femoral pulses were normal.

Routine laboratory procedures were within normal limits on the last admission. Roentgenograms of the thorax showed some basal pneumonitis. Heart size was normal. Barium swallow demonstrated a prominent defect on the posterior aspect of the esophagus at the level of T-4 (Fig. 2). This was interpreted as compatible with an anomalous artery compressing the esophagus. Tracheogram and endoscopic examination did not seem to be indicated. From the clinical history, objective signs, and esophagogram studies, an obstructing vascular ring was suspected as the cause of the

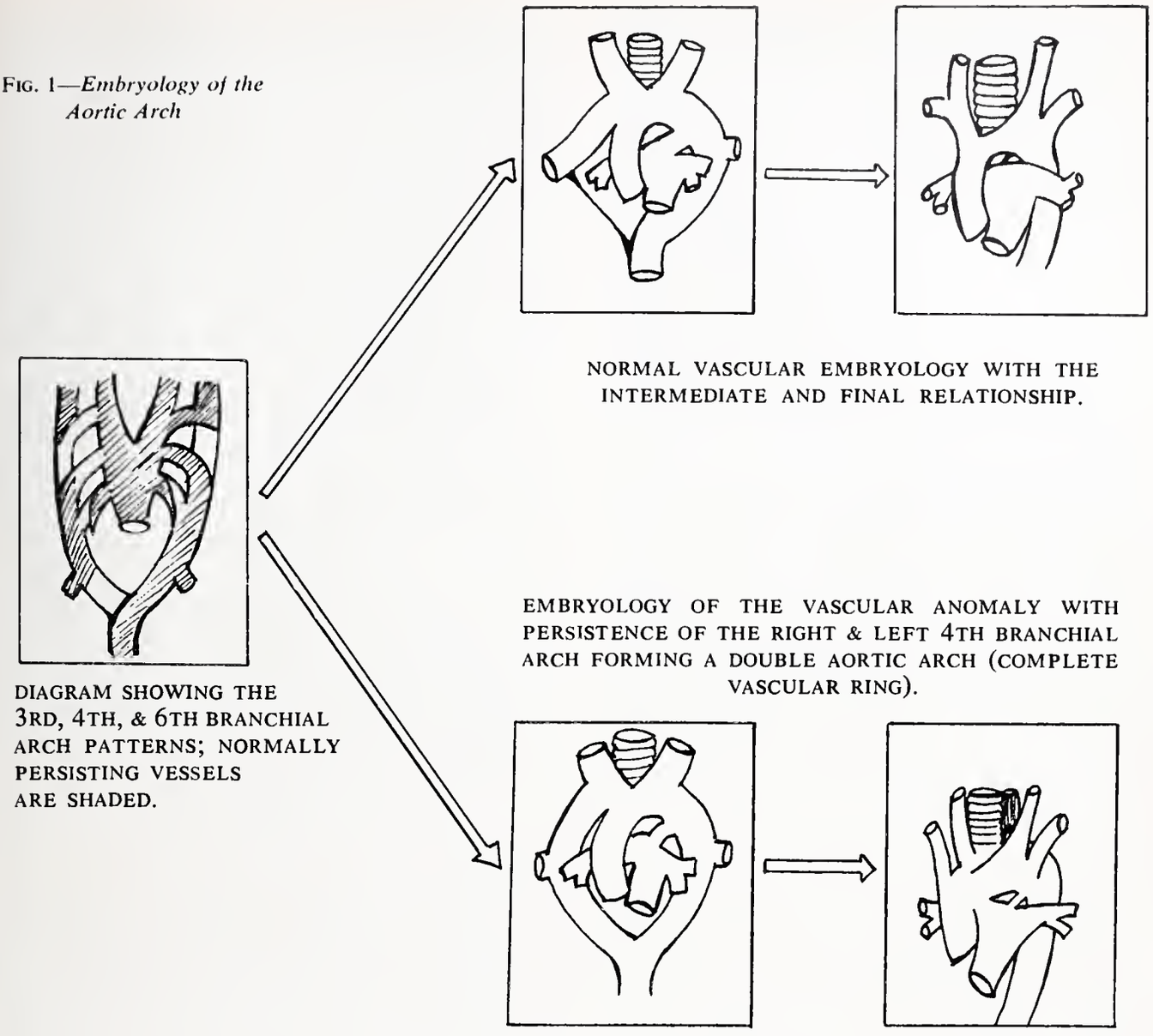



FIG. 1—*Embryology of the Aortic Arch*

infant's distress. Surgical intervention was recommended to the parents and they willingly accepted it.

The chest was entered on the left side through a postero-lateral incision at the level of the fourth interspace. The thymus and phrenic nerve were dissected anteriorly to expose the aortic arch. Careful attention was placed on the location of the left recurrent laryngeal nerve. The ligamentum arteriosum was ligated and divided. The left subclavian, the left common carotid, and the right common carotid arteries seem to arise and course in a normal fashion. The diagnosis of complete vascular ring was confirmed. There was a large posterior arch and a small anterior arch with the connection of the anterior arch to the posterior arch being the smallest portion of the complete vascular ring. The left common carotid and left subclavian arteries came from the anterior aortic arch (Fig. 1).

It was elected to divide the anterior arch distal to the left subclavian at its smallest point before it joined the posterior arch forming the descending thoracic aorta. Attempt to do an operative angiography to visualize the complete vascular ring was unsuccessful, other than revealing that the descending thoracic aorta was located on the left side of the chest cavity. After division and oversewing of the ends of the anterior aortic arch, the vessels retracted providing enough space for the trachea and esophagus. The infant's postoperative course was uneventful. Feeding became easy and the infant's breathing was far less noisy (Fig. 3).

## DISCUSSION

Most of the patients with this anomaly exhibit compression symptoms of the esophagus and trachea because of the limited space between the two arches. Complete vascular ring has been re-



FIG. 2.—*Barium swallow demonstrating a prominent defect on the posterior aspect of the esophagus at the level of T-4. This is compatible with double aortic arch.*



FIG. 3.—*Attempted angiography to visualize the complete vascular ring was unsuccessful other than revealing that the descending thoracic aorta is located on the left side.*

ported in adults without any symptoms. However, this anomaly is usually a serious one, often leading to death within the first year or two of life if not diagnosed and surgically treated. Most of these individuals with double aortic arches are prone to pulmonary infection.

Symptoms are far more common than in the incomplete vascular ring, and usually occur at an earlier age. Signs of tracheal obstruction usually begin in the first or second month after birth and progress rapidly during the third and fourth months. Respiratory difficulties are usually accentuated after feeding, due to distension of the esophagus during swallowing, which further compresses the trachea. Pulmonary infection due to food aspiration complicates the existing respiratory problem and makes the condition of the child more grave. Whenever a baby has respiratory difficulty in the first six months of life, a vascular ring should be suspected. There may be subcostal or suprasternal retraction. There is apt to be a "crowing" type of respiration with marked stridor. The child may assume a position of hyperextension of the head. This position attenuates the trachea and pushes away the anterior aortic arch.

Plain x-ray films will give a clue concerning the presence of complete vascular ring. Newhauser has pointed out that, in the presence of persistent ring and left aortic arch, the aortic knob is more or less equally divided between the two sides of the mediastinal shadow. Heavily exposed films may demonstrate a narrowing of the lower third of the trachea in the lateral projection. Inspiratory chest films may show poor aeration of the lungs, while expiratory chest films show the lungs to be hyperaerated. Esophagograms show transverse compression of the esophagus posteriorly at the level of T-3 or T-4. Tracheogram using lipiodol gives a clear picture of the anterior and lateral compression of the trachea. The presence of pulsation of the compressed posterior wall of the esophagus on fluoroscopy may serve to differentiate a double aortic arch from one wherein the ligamentum arteriosum is a component of the anomalous vascular ring. Aortogram, intravenous injection, or retro-arterial injection give excellent visualization of the arch system, but this is seldom necessary, according to Gross.

Complete vascular ring generally requires an operation before the infant reaches six months of age. Surgical therapy has much to offer these patients, because division of the smaller component of the double aortic arch provides more space for the trachea and esophagus. Since Gross first described the surgical treatment of this condition in 1945, the outlook for such a vascular anomaly

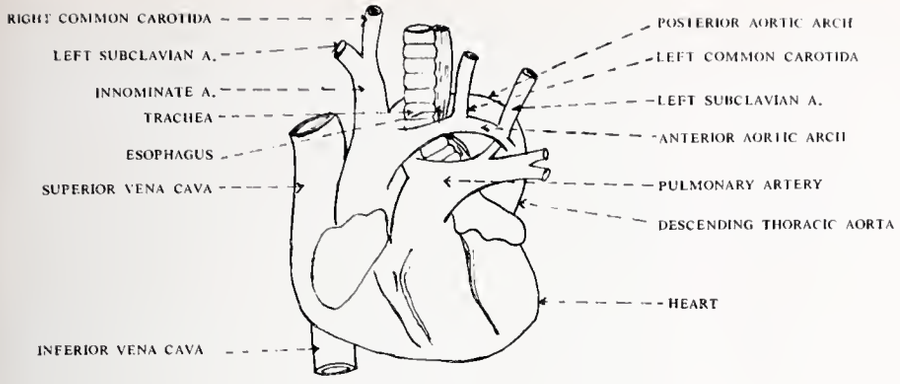



FIGURE 2.

FIG. 4.—*Arrangements of the great vessels as found on operation: The ascending aorta divides into two branches, a large posterior branch passing behind the esophagus and a smaller anterior branch in front of the trachea. The two arches form the complete vascular ring, causing obstruction of the esophagus and trachea.*



FIG. 5. — *Surgical procedure: The ligamentum arteriosum was divided to allow the pulmonary artery to displace forward. The anterior aortic arch was divided just before it joins the posterior aortic arch to relieve compression of the trachea and esophagus.*

has been excellent. It is always possible to divide a complete vascular ring because one of the arches is invariably smaller and less functionally significant. Commonly, the posterior arch passing behind the esophagus is the larger and is the one retained and not divided. Division of the anterior arch gives sufficient room for the trachea and esophagus. The best point of division is between the left common carotid artery and the left subclavian artery. Sometimes it is necessary to suture the divided left common carotid artery to the posterior surface of the sternum, thus lifting it anteriorly. The ligamentum arteriosum should be divided to allow the pulmonary artery to fall forward, thus adding to the relief of compression symptoms.

Results after surgical therapy have been rewarding. Improvement in respiratory exchange has been noted immediately after operation and the stridor usually disappears. In Gross's series of 26 cases, age ranging from one month to three years, there were 16 cases with a normally-located descending thoracic aorta. Eleven of the 16 cases had a smaller anterior aortic arch and five had smaller posterior aortic arch. The remaining ten cases had a right-sided descending thoracic aorta. Most of these cases had a smaller posterior aortic arch. There were five deaths among these 26 cases of complete vascular ring. Two died from hemorrhage on the operating table, one from cerebral edema, and three from pneumonia. In Mustard's series of 13 cases, there were three deaths.[9] One died during the process of intubation, one from obstructed tracheostomy tube, and the other from a tracheal tube which was not able to support the collapsed trachea. There were six cases operated upon at the Grace–New Haven Community Hospital without mortality, and all were completely relieved of symptoms. ■

P. O. Box 1083, Ewa, 96706

REFERENCES

1. Benson, C. O., Mustard, W. T., Ravitch, M. W., Snyder, W. H., and Welch, K. J., Pediatric surgery, Chicago, Year Book Medical Publishers Inc., 1962.
2. Bernatz, P., Lewis, D., and Edwards, J.: Division of posterior arch of a double aortic arch for relief of tracheal and esophageal obstruction, Mayo Clin. Proc. 34:173-176 (Apr.) 1959.
3. Gibbon, John H.: Surgery of the chest, Phil., W. B. Saunders Co., 1962, pp. 550-555.
4. Gross, R. E.: Surgical relief for tracheal obstruction from vascular ring, New Eng. J. Med., 233:486-590 (Nov. 15) 1945.
5. Gross, R. E., and Newhauser, E. B.: Compression of the trachea or esophagus by vascular anomalies; surgical therapy in 40 cases, Pediatrics 7:69-88 (Jan.) 1951.
6. Gross, R. E.: The surgery of infancy and childhood: its principles and techniques, Phil., W. B. Saunders Co., 1953, pp. 913-935.
7. Gross, R. E.: Circulation, 11:1:124-134 (Jan.) 1955.
8. Newhauser, E. B.: Tracheo-esophageal constriction produced by right aortic arch and left ligamentum arteriosum, Amer. J. Roentgen. 62:493-499 (Oct.) 1949.
9. Mustard W. T., Trimble, A. W., and Trusler, G. A.: Mediastinal vascular anomalies causing tracheal and esophageal compression and obstruction in childhood, Canad. Med. Ass. J. 87:1301-1305 (Dec.) 1962.
10. Watkins, E., and Hering, A.: Compression of the trachea and esophagus by anomalous great vessels, Surg. Clin N. Amer. 41:3:821 (June) 1961.

*A kink in his internal carotid artery which caused this man to have a hemiplegia was corrected by resecting a segment of the common carotid artery.*

# Internal Carotid Artery Kinking

GORDON LIU, M.D., WILLIAM W. T. WON, M.D., and
WALTER Y. M. CHANG, M.D., *Honolulu*

• *Internal carotid artery kinking as a cause of cerebrovascular symptoms has been described by previous writers.*[1, 2, 3] *This entity, however, has been relatively uncommon. Prior to this report, no cases of this nature have been seen at St. Francis Hospital.*

RECENTLY, we have successfully treated a case of internal carotid artery kinking which was the cause of hemiplegia. Furthermore, this disorder was successfully treated by a technique which seemed ready made for this situation.

## CASE REPORT

A 67-year-old Filipino man had diplopia on February 8. Two days later, there was a definite right hemiplegia. These difficulties were transient and he was able to continue working. However, diplopia and weakness of the right side of his body returned. Because of difficulty with writing, he was unable to complete his signature on a check while at work. He then developed weakness again of his right arm and leg, with some slurring of speech. His past medical history revealed that he had been treated for hypertension with chlorothiazide, which was discontinued on admission to the hospital.

Physical examination showed a 67-year-old Filipino man with no obvious abnormalities of his head and neck. Carotid pulsations were good and there was no bruit on either side. His tongue and facial muscles were normal and his blood pressure was 180/90 mm of mercury. He had an increase in the anterior-posterior diameter of his chest, but his lungs were otherwise normal. Pulse and heart rate were 60 beats per minute. The abdomen was moderately obese, but there were no masses or tenderness. The pulses in the extremities were all excellent. There was no bruit anywhere.

The complete blood count, urinalysis, serum creatinine, cholesterol, sodium, chloride, and carbon dioxide combining power were normal. Blood urea nitrogen was 31 mg %, serum potassium 2.9 mEq per liter, and the two-hour postprandial blood sugar was 122 mg % on February 21. On February 28, the potassium was 3.7 mg %. A repeat blood urea nitrogen was 24 mg %. On March 14, the serum potassium was 3.4 mg %.

The results of the spinal tap on February 20 were normal. An electrocardiogram showed nonspecific ST-T changes with left ventricular hypertrophy and a chest x-ray also showed left ventricular enlargement with a slightly widened aorta.

Because of the strong suspicion of a vascular occlusion as the cause of his cerebral difficulties, arteriographic studies were done. All the great vessels rising from the arch of the aorta appeared to be normal. However, a left carotid arteriogram showed kinking of the left internal carotid artery high under the angle of the left mandibular ramus. Furthermore, the dye was held up at this particular area for at least six seconds while he had his head flexed. On hyperextension of his head, the dye, and therefore the blood, flowed through much more rapidly. It was evident, that with his head in the flexed position, the kinking or buckling of the left internal carotid artery high under the angle of the left mandibular ramus caused an obstruction to the blood flow in the carotid artery (Fig. 1).

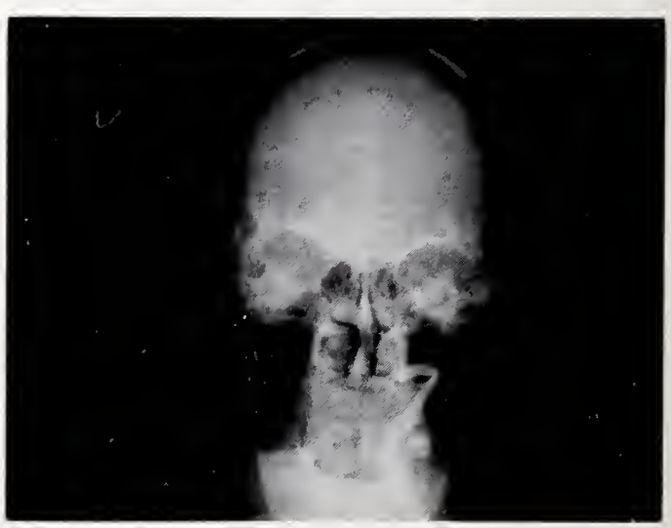


FIG. 1.—*Carotid arteriogram showing kink of left internal carotid artery. Dye is obstructed and present in artery even after six seconds have elapsed after inspection.*

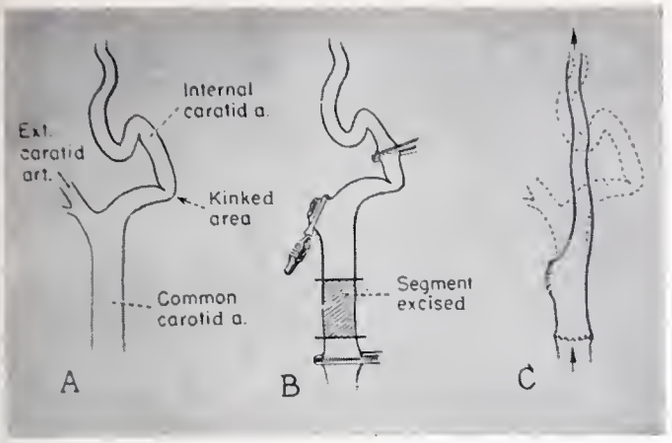



FIG. 2.—*Diagram showing the indirect technique of treating internal carotid artery kink.*

On March 4 his left neck was explored. The internal carotid artery kink was found to be very high under the angle of the left mandibular ramus. In addition to this, the diameter of the left internal carotid artery measured less than 5 mm. There were no arteriosclerotic plaques in the area, but an obvious kinking or buckling of the internal carotid artery prevented adequate blood flow through this area. The bifurcation of the common carotid artery was also very high under the ramus of the left mandible, and the diameter of the internal carotid artery even at its origin was small.

Because of the difficulty of resecting the kink in such an inaccessible area, an indirect attack was carried out. The vessels were freed by sharp and blunt dissection and the external carotid artery was ligated and divided near its origin. The kink of the left internal carotid artery was then straightened out and a two-centimeter segment of the common carotid artery was excised. It was noted that there was a small area of dissection between the media and adventitia due to the arteriogram. A small clot present there was removed. Over an internal shunt, the two ends of the common carotid artery were anastomosed with 0000 vascular silk. This anastomosis was done in a more easily exposed area and with arteries much larger than the narrow internal carotid branch. He did well postoperatively and was discharged on March 15 in good condition (Fig. 2).

## DISCUSSION

Although hemiplegia caused by internal carotid artery kinking has been documented in the past, this particular entity had not been seen previously at St. Francis Hospital. The delay of blood flow to the brain with the head in a flexed position was dramatically demonstrated by arteriographic studies of the carotid arteries. Even after six seconds, it was still possible to demonstrate dye remaining in the common carotid artery because of the buckle of the narrow internal carotid branch. Most cerebrovascular symptoms and accidents have been due to arteriosclerotic occlusions or thromboses. Kinking as a rare cause deserves mention. Elongation and kinking are probably the result of hypertension.

Treatment for this abnormality has been resection of the internal carotid artery kink with primary anastomosis of the two ends of the internal carotid branch. Proximal transplantation of the origin of the internal carotid branch to a point further down on the common carotid artery also has been advocated. Either of the above techniques would have been difficult to use in this case because of the small caliber of the internal carotid artery and also because of the high position of the left common carotid artery bifurcation. The indirect procedure described in the above case report should supersede the other two techniques in most situations in which there is an internal carotid artery kink. Even with arteriosclerotic plaques present, endarterectomy need merely be added as an adjunctive procedure. Certainly, resection of small vessels in practically inaccessible areas is difficult. Proximal transplantation of the origin of the internal carotid artery is also hazardous when the diameter of the internal carotid artery is small. Endarterectomy at this area also causes considerable fraying of the origin of the internal carotid artery. For this reason, we advocate this indirect technique of freeing the carotid vessels, ligating and dividing the external carotid artery, straightening the kink, and resecting the larger and more accessible common carotid artery segment with primary anastomosis as the procedure of choice in the treatment of internal carotid artery kinking.

## CONCLUSIONS AND SUMMARY

A case of an internal carotid artery kink with the bifurcation of the common carotid artery high under the mandible has been reported. This entity was the cause of cerebrovascular symptoms. The disease was successfully treated by means of an indirect technique in which the kink was straightened out but the resection was carried out in a more easily exposed area of the neck. Anastomosis with the larger common carotid artery was carried out. This indirect technique is strongly advocated as the procedure of choice in internal carotid artery kinking. ■

1024 Piikoi St., 96814

## REFERENCES

1. Gass, H. H.: Kinks and coils of cervical carotid artery, Surg. Forum 9:721-724, 1958.
2. Quattlebaum, J. K., Jr., Upsom, E. T., and Neville, R. L.: Stroke associated with elongation and kinking of internal carotid artery: report of three cases treated by segmental resection of common carotid artery, Ann. Surg. 150:824-832 (Nov.) 1959.
3. Najafi, Hassan, Javid, Hushang, Dye, William S., Hunter, James A., and Julian, Ormand C.: Kink in the internal carotid artery, Arch. Surg. 89:134-143 (July) 1964.

*A relatively uncommon tumor in the Mainland is relatively common here.*

# Hepatoma

## A Clinical and Pathologic Study of Cases Occurring During 1950-1959 in Hawaii

PAUL Y. TAMURA, M.D., and ANN B. CATTS, M.D., *Honolulu*

• *Hawaii, with its admixture of races, affords a unique opportunity to study the relative incidences of tumors and diseases. The incidence of primary hepatic cancer is proportionately higher in Hawaii than it is in the continental U.S.*

*The higher incidence of hepatic cancer in Hawaii, compared to the U.S. as a whole, is due to the Oriental population in whom this condition exists more often than in Caucasians.*

*Quisenberry, in a review of 3,257 malignancies, noted the highest incidence of primary liver cancer in Filipinos, followed by Japanese, Chinese, Hawaiians, and Caucasians, in order.*

IN 1960, we undertook a review of cases collected from The Queen's Hospital, St. Francis Hospital, Kuakini Hospital, and Hilo Memorial Hospital. This is an attempt to study the clinical and pathologic aspects of the cases collected from these hospitals. There were 67 cases occurring during a ten-year period from 1950-1959. It is our impression that these constituted the majority of the known cases in Hawaii occurring during this period of time. Unfortunately, it was necessary to eliminate 24 cases for lack of acceptable histologic confirmation. Two were sarcomas, leaving 41 cases for this study.

### AGE

The ages ranged from 14 months to 81 years (Table 1). The cases at either extreme were males. The youngest woman was 35 years and the oldest, 73. The average age for males is 56 years and for

TABLE 1.—*Distribution by age groups.*

| AGE GROUPS (YRS.) | NO. |
|---|---|
| 0- 4 | 1 |
| 5- 9 | |
| 10-19 | |
| 20-29 | |
| 30-39 | 3 |
| 40-49 | 4 |
| 50-59 | 14 |
| 60-69 | 15 |
| 70-79 | 3 |
| 80-89 | 1 |
| TOTAL | 14 |

TABLE 2.—*Cases dying in hospitals with diagnosis of hepatoma (1950-1959)*

| RACE | NUMBER OF CASES | | |
|---|---|---|---|
| | MALE | FEMALE | TOTAL |
| Caucasian | | 3 | 3 |
| Chinese | 2 | | 2 |
| Filipino | 14 | | 14 |
| Hawaiian–Part-Hawaiian | 5 | 2 | 7 |
| Japanese | 8 | 3 | 11 |
| Korean | 3 | 1 | 4 |
| TOTAL | 32 | 9 | 41 |

females, 61 years. Seventy-one per cent of the patients were between 50 and 69 years.

RACE

The racial distribution is as indicated in Table 2. The largest group represented was Filipino. This group was followed by Japanese with 11 cases and the Hawaiian group (including part-Hawaiians) with seven cases. The Koreans, Caucasians, and Chinese had four, three, and two cases, respectively. It is hazardous to draw conclusions regarding racial incidences from this breakdown alone.

The Hawaiian and part-Hawaiian group includes a variety of races and was therefore eliminated from analyses in Tables 3 and 4. The one case in a 14-month-old was also excluded from these tables. In Table 3, the racial groups are compared with each population group aged 30 years and older. The Koreans have the highest rate per 100,000. Data from previous studies[2, 3] also suggest this. Statistics from the Hawaii Tumor Registry from 1960-1964 indicate the incidence to be approximately 25/100,000, not age corrected. I believe this deserves further study. Perhaps an inquiry in Korea may be rewarding. Following the Korean group is the Filipino. The Chinese and Japanese rates are equal, with the Caucasian rate being the lowest. With regard to the latter statement, it is immediately apparent that the data for the Caucasian seem to be completely unreliable. In all studies, hepatoma is more common in men than among women. The skewed distribution with regard to the Caucasians is, therefore, highly suspect. The only statement we can make with this study is that Caucasians are less prone to hepatoma than the Asian group.

In Table 4, the cases are separated into three broad age groups: 30-44 years, 45-59 years, and 60 years and over. The Filipinos show the highest rate, except in the oldest group, and the Chinese the lowest. However, all the Filipino cases occurred after age 60, so that this age group shows rates in the following ascending order: Japanese, Filipino, Chinese, Korean. This shows that the very high risk in Koreans is among the older people.

SEX AND HISTOLOGIC TYPES

Twenty-two of these cases were confirmed by surgical biopsy alone; nine by autopsy alone; and ten by both. Where available, the histologic material was reviewed for the purpose of uniform classification, but where unavailable, a microscopic description was utilized.

The tumors were divided into liver-cell, bile-duct, and mixed types (Table 5). Some authors group the mixed variety with the liver-cell type. The mixed and liver-cell types predominate in men with six times the incidence in women. The bile-duct type, however, predominates in women, with four out of five cases.

CIRRHOSIS

Twenty-six cases showed cirrhosis (Table 3). History of alcoholic intake was obtained in seven cases, all of whom showed cirrhosis. Twenty-two of the 28 cases of liver-cell carcinoma occurring in men, or four out of five cases, were associated with cirrhosis. There was cirrhosis in only one of the cases in women. All of the cases with mixed ductal and hepatocellular elements were in men and were associated with cirrhosis. This would

TABLE 3.—*Rates of hepatoma cases dying in hospitals, 1950-1959, ages 30 years* and over.***

| RACE | MALE | | | FEMALE | | | TOTAL | | |
|---|---|---|---|---|---|---|---|---|---|
| | *1960 Population* | *No. of Cases* | *Rate per 100,000* | *1960 Population* | *No. of Cases* | *Rate per 100,000* | *1960 Population* | *No. of Cases* | *Rate per 100,000* |
| Caucasian | 41,687 | | | 37,155 | 3 | 8.07 | 78,842 | 3 | 3.81 |
| Chinese | 9,670 | 2 | 20.68 | 8,900 | | | 18,570 | 2 | 10.77 |
| Filipino | 25,996 | 14 | 53.85 | 6,976 | | | 32,972 | 14 | 42.46 |
| Japanese | 48,182 | 7 | 14.53 | 50,469 | 3 | 5.94 | 98,651 | 10 | 10.14 |
| Korean | 4,035 | 3 | 74.35 | 4,267 | 1 | 24.78 | 8,302 | 4 | 45.18 |

* One child 14 months of age does not appear in subsequent tables.
** Population figures for Koreans estimated from data supplied by the Hawaii State Department of Health.

TABLE 4.—*Differences in rates of hepatoma cases per 100,000 population* by gross age breakdown.*

| RACE | MALE | | | FEMALE | | | TOTAL | | |
|---|---|---|---|---|---|---|---|---|---|
| | *1960 Population* | *No. of Cases* | *Rate per 100,000* | *1960 Population* | *No. of Cases* | *Rate per 100,000* | *1960 Population* | *No. of Cases* | *Rate per 100,000* |
| | | | | 30-40 YEARS OF AGE | | | | | |
| Caucasian | 24,717 | | | 20,776 | | | 45,493 | | |
| Chinese | 4,520 | | | 4,627 | | | 9,147 | | |
| Filipino | 6,187 | 1 | 16.16 | 4,099 | | | 10,286 | 1 | 9.72 |
| Japanese | 25,151 | 2 | 7.95 | 28,074 | 1 | 3.56 | 53,225 | 3 | 5.64 |
| Korean | 464 | | | 609 | | | 1,073 | | |
| | | | | 45-59 YEARS OF AGE | | | | | |
| Caucasian | 11,739 | | | 10,312 | 1 | 9.70 | 22,051 | 1 | 4.53 |
| Chinese | 3,165 | 1 | 31.60 | 2,795 | | | 5,960 | 1 | 16.78 |
| Filipino | 14,773 | 11 | 74.46 | 2,046 | | | 16,819 | 11 | 65.40 |
| Japanese | 6,658 | 4 | 60.08 | 7,519 | 2 | 26.60 | 14,177 | 6 | 42.32 |
| Korean | 241 | | | 233 | | | 560 | | |
| | | | | 60 YEARS OF AGE AND OLDER | | | | | |
| Caucasian | 5,231 | | | 6,067 | 2 | 32.97 | 11,348 | 2 | 17.62 |
| Chinese | 1,985 | 1 | 50.38 | 1,478 | | | 3,163 | 1 | 31.62 |
| Filipino | 5,036 | 2 | 39.71 | 831 | | | 5,867 | 2 | 34.09 |
| Japanese | 9,393 | 4 | 42.58 | 9,756 | 2 | | 19,149 | 6 | 31.33 |
| Korean | 99 | 3 | 3030.30 | 140 | 1 | 714.29 | 153 | 4 | 2614.38 |

* Population figures for Koreans estimated from data supplied by the Hawaii State Department of Health.

seem to justify considering these cases with the hepatocellular group rather than as a separate entity. (The case of sarcoma in an elderly man was associated with cirrhosis, but the case in the woman was not.)

## CLINICAL PICTURE

It was not possible to determine the duration of symptoms prior to diagnosis, since occasionally a long history of vague symptoms was present. However, once symptoms were definite enough to lead to diagnosis, the patient's survival period was short: between 3.75 and 4.50 months.

Most agree that the clinical picture and course may vary widely.[1, 4, 8, 9] We note in our series that clinicians considered malignancy 19 times prior to confirming surgery or autopsy or both. Liver was considered to be the site of malignancy eight times; stomach, intestines, or gastrointestinal tract (unspecified) 10 times; and the gallbladder once. Of the noncancerous diagnoses, cirrhosis was considered in eight and gallbladder disease was considered in seven cases. Two of the latter had "classical" gallbladder picture, with qualitative dyspepsia, bloating, and belching for "years." No noticeable difference exists in clinical manifestations among different histologic types.

The presence of an abdominal mass was the most common manifestation, occurring in 29 (71%) of the cases (Table 6). In a majority of instances, 21 patients, this was interpreted as liver enlargement. Abdominal pain or tenderness, or both, were noted in 26 cases, but in eight instances were not associated with liver enlargement or abdominal mass. Nausea, vomiting, or anorexia was noted in 13 cases, emaciation and weight loss in 11 cases, and weakness in eight cases. These symptoms in elderly individuals contributed to the general impression of malignancy.

Jaundice was present in 12 cases and augured serious involvement. There was venous involve-

TABLE 5.—*Distribution of primary liver cancer by histologic types, sex and cirrhosis.*

| HISTOLOGIC TYPES | MEN | | WOMEN | |
|---|---|---|---|---|
| | *Total* | *Cirrhosis* | *Total* | *Cirrhosis* |
| Liver Cell | 28 | 22 | 5 | 1 |
| Bile Duct | 1 | | 4 | |
| Mixed | 3 | 3 | | |
| Sarcoma | 1 | 1 | 1 | |
| TOTAL | 33 | 26 | 10 | 1 |

TABLE 6.—*Signs and symptoms.*

| SIGNS & SYMPTOMS | NUMBER | PERCENT |
|---|---|---|
| Abdominal Mass | 29 | 71 |
| "Liver Enlargement" | 21 | |
| Abdominal Pain and/or Tenderness | 26 | 63 |
| Not Associated with Abdominal Mass | 8 | |
| Nausea, Vomiting, Anorexia | 13 | 32 |
| Jaundice | 12 | 29 |
| Emaciation, Weight Loss | 11 | 27 |
| Weakness | 8 | 20 |
| Hematemesis | 6 | 15 |
| Ascites | 6 | 15 |
| Diabetes | 6 | 15 |
| Tarry Stools | 5 | 12 |
| Shock | 3 | 7 |

TABLE 7.—*Laboratory findings.*

| | | |
|---|---|---|
| Hb | 10 Gms | 27% |
| Bilirubin | 1 mgm% | 92% |
| | 25 mgm% | 15% |
| BSP | | 90% |
| Cephalin Floc | | 83% |
| Thymol Turb. | 3 Units | 50% |
| Kunkel | 10 Units | 89% |
| Alkaline Phosphatase | 4 Bod. u.<br>8 Shinowara u.<br>13 King Armstr. u. | 87%* |
| Prothrombin Time | 50% | 23% |
| Protein | | |
| Total | Depressed | 6% |
| Albumin | Depressed | 69% |
| Globulin | Elevated | 75% |

* At upper limit of normal, slightly abnormal.

ment—portal, hepatic, or inferior vena caval—in four cases. There was cholangitis in two cases. The extrabiliary duct system was involved in one case and there was ascites in one. Eight of the 12 cases were of liver-cell type, and there were two each of bile duct and mixed types. Though the liver-cell type is numerically more common, this type is not proportionately commoner than other histologic types.[1] The highest bilirubin level was in the bile duct type, 27 mgm%. The second highest level was 25 mgm%, in a case of hepatic cell type.

Bleeding may be a prominent feature.[10, 11] Hematemesis in six cases and tarry stools were noted in five. Shock was noted in three cases, one associated with hematemesis due presumably to esophageal varices. Two were associated with hemorrhage due to rupture of a tumor nodule. One of the latter was, in addition, associated with esophageal varices. Ascites was prominent in six cases.

## LABORATORY FINDINGS

The laboratory studies in many of the cases, particularly early in the series, were inadequate. Nevertheless, we find that our data are not unlike those reported by others[9, 12] (Table 7).

Three out of 11 cases showed anemia, with hemoglobin below 10 gms (9.7, 7.2, and 5.0 gms). None showed elevation of hemoglobin or hematocrit, a point we sought in view of the cases of hepatoma associated with erythrocythemia.[11, 12] The ABO blood types of 13 patients were: four type O; four type A; one type B; and four type AB.

Nearly all patients tested had abnormality of one or more liver function studies. The most commonly utilized study, bilirubin, showed abnormality in 92 per cent. Abnormal bromsulphalein retention occurred in nine out of ten cases. Considering cephalin flocculation and thymol turbidity and Kunkel together, 74 per cent of the cases tested were abnormal. The alkaline phosphatase was at the upper limit of normal or slightly elevated in seven out of eight cases in which it was performed. Hyperphosphatasemia is not very helpful in distinguishing individual cases of cirrhosis from carcinoma.[14] Prothrombin time was less than 50 per cent in about one-fourth of the cases tested.

Serum total protein values were misleading. Only one of 16 cases tested had a significantly low total protein level. Yet albumin was depressed in 11 out of 16 cases (69 per cent) and the globulin was elevated in 12 out of 16 cases. Dysproteinemia has been reported with hepatoma,[12] but unfortunately, no electrophoretic studies were done on these cases. There was albuminuria in six cases.

There were six cases with clinical diagnosis of diabetes. No case of hypoglycemia was present in this series.

We had four cases with positive serologic tests for syphilis: two Hawaiians, a Korean, and a Filipino. There has been some speculation in the past that syphilis might be related etiologically to hepatoma.[14] Rather than the disease, its now antiquated therapy may have been an important factor. With multiple injections, there is exposure to heavy metals and also a greater possibility of hepatitis. Only one case had a history of therapy with bismuth and neoarsphenamine. The possibility of false positives due to abnormal globulins was considered, but no electrophoretic studies were available.

## PATTERNS OF METASTASIS

Based on 19 autopsied cases and two additional cases where surgical exploration and clinical search had been made, 12 cases showed metastasis. In ten instances, the metastasis was to the lungs and in four, the lymph nodes. San Jose[12] also found the lung and lymph nodes the most common sites of metastasis in a review of 80 cases. Nearly every tissue in the body including brain, heart, bladder, adrenals, and bones was involved in one or two cases each.

## INCIDENTAL FINDINGS

Incidental findings include one each of polycystic kidneys, thyroid adenoma, congenital aneurysm of the left internal carotid artery, and squamous cell carcinoma of the tongue.

## SUMMARY

Forty-one cases of hepatoma occurring in Hawaii between 1950-1959 were studied from the clinical and pathologic standpoint. The incidence

in Orientals is high. Approximately three-fourths of the cases were in the 50-69 age group. These are the so-called "migrant groups" from the Orient. The Filipinos constituted the largest group of cases but the Koreans had the highest rate per 100,000. The highest risk in Koreans is among the older people.

The hepatocellular tumor occurred mainly in men, and in 80 per cent of cases was associated with cirrhosis. The bile-duct type was usually seen in women. In women, with either type of tumor, cirrhosis was uncommon. While the clinical picture could vary widely, most presented with abdominal mass or pain, usually referable to the liver. Together with nausea, vomiting, emaciation, and weight loss, the impression of malignancy was produced. Laboratory studies collectively in majority of instances indicated liver abnormality. Once diagnosed, survival was very short.

ACKNOWLEDGMENTS

We are grateful to Kuakini, St. Francis, and Hilo Memorial Hospitals, their respective administrators, staff, and clinicians, without whose cooperation and help this type of study would not have been possible. We are also grateful to Mrs. Martha Bruyere, Consulting Biostatistician to the HAWAII MEDICAL JOURNAL, who prepared Tables 2, 3, and 4. ■

1010 So. King St., 96814

REFERENCES

1. Edmondson, H. A.: Tumors of the liver and intrahepatic bile ducts, Atlas of Tumor Pathology Sec. VII-FASC. 25 AFIP Washington, D.C., 1958.
2. Quisenberry, W. B., and Tilden, I. L.: Racial incidence of cancer in Hawaii. A study of 3,257 cases of malignant neoplastic disease, HAWAII MED. J. 13:449-451 (July-Aug.) 1954.
3. Quisenberry, W. B.: Ethnic differences and socio-cultural factors in cancer in Hawaii, Med. Arts and Sciences XV:107-119, 1961.
4. Edmondson, H. A., and Steiner, P. E.: Primary carcinoma of the liver: a study of 100 cases among 48,900 necropsies, Cancer 7:462-503 (May) 1954.
5. Yeh, S., and Cowdry, E. V.: Incidence of malignant tumor in Chinese, especially in Formosa, Cancer 7:425-436 (May) 1954.
6. Tamura, P. Y.: Some disease peculiarities in Hawaii, HAWAII MED. J. 20:235-239 (Jan.-Feb.) 1961.
7. U.S. Census of Population, 1960: Nonwhite population by race P C (2) 1 C, Table #61; Hawaii Detailed Characteristics P C (1) 13 D, Table #94.
8. Patton, R. B., and Horn, Jr., R. C.: Primary liver carcinoma: autopsy study of 60 cases, Cancer 17:757-768 (June) 1964.
9. Nelson, R. S., de Elizalde, R., and Howe, C. D.: Clinical aspects of primary carcinoma of the liver, Cancer 19:533-537 (Apr.) 1966.
10. Storment, A. M., Kehoe, E., and Cohen, R.: Hepatoma with massive hemorrhage: report of three cases, Calif. Med. 102: 446-449 (June) 1965.
11. Fox, H., and Schofield, P. F.: Haemoperitoneum complicating primary hepatic carcinoma, Brit. J. Surg. 52:711-713 (Sept.) 1965.
12. San Jose, D., Cady, A., West, M., Chomet, B., and Zimmer, J. J.: Primary carcinoma of the liver. Analysis of clinical and biochemical features of 80 cases, Amer. J. Dig. Dis. 10:657-674 (Aug.) 1965.
13. Libre, E. P., and Rodilosso, P. T.: Hepatoma with dysproteinemia and erythrocythemia, Arch. Interm. Med. 115:48-52 (Jan.) 1965.
14. Payet, M., Moulanier, M., Sankale M., and Pene, P.: Alkaline phosphatase in primary cancer of the liver, Path. et Biol. 13/15-16/17-18 (743-747) Excerpta Medica-Cancer 14:803 4006 (Aug.) 1966.
15. Wells, R. F., and Lundberg, G. D.: Hepatoma: review of 43 cases with comments on syphilis as an etiologic factor, Gastroenterology 44:598 (May) 1963.

*A ruptured aneurysm may be surgically curable if it has ruptured into the duodenum as this one did.*

# Primary Aortoduodenal Fistula Due to Rupture of Aortic Aneurysm

WALTER Y. M. CHANG, M.D., and GORDON LIU, M.D., *Honolulu*

• *A 67-year-old man who had recently collapsed with hemorrhage into the intestine was found to have a pulsating abdominal mass which was found at laparotomy to be an aneurysm of the abdominal aorta, ruptured into the duodenum. Resection was accomplished.*

MASSIVE gastrointestinal tract hemorrhage due to a primary aortoduodenal fistula caused by rupture of an arteriosclerotic abdominal aortic aneurysm is rare.[1, 2] Most aortoduodenal fistulas have been secondary to leakage from synthetic graft replacements.[2] There have been about 50 cases of primary aortoduodenal fistulas, the vast majority of which have been diagnosed postmortem.[2, 3]

The rarity of this disease is evident, but survival after surgical treatment is even more unusual.[1] There are apparently only four cases of survival reported in literature. Of the four, only three cases were diagnosed preoperatively.[2, 4]

The purpose of this report is to describe a case of primary aortoduodenal fistula due to a ruptured arteriosclerotic abdominal aortic aneurysm which was diagnosed preoperatively and successfully treated.

## CASE REPORT

A 67-year-old Caucasian dentist was in his usual state of health until the evening of April 24, 1966, when he was found in shock on the floor of a restaurant. While eating, he had become nauseated, vomited up his meal, and promptly collapsed. When he was brought to the hospital, he defecated black and red blood. He then regained consciousness and complained of some mild, vague lower abdominal discomfort.

He had had two heart attacks, the first seven years ago and the second a year ago. The latter attack was supposedly mild, but severe epigastric pains were described and were attributed to a small duodenal ulcer.

Physical examination revealed a cooperative, 67-year-old white man whose blood pressure was 80/50 and whose pulse was 60 per minute. The head, neck, lungs, and heart were within normal limits. There was a large, pulsating mass in the upper abdomen but no bruit or tenderness were present. He had normal bowel sounds. Rectal examination revealed black-red stools. Pulses in the femoral areas were equal and excellent bilaterally. The right popliteal, dorsalis pedis, and posterior tibial pulses were strong, but his left popliteal, posterior tibial, and dorsalis pedis pulses were not palpable.

An electrocardiogram revealed no evidence of myocardial infarction. A Levine tube was inserted and coffee ground material aspirated from his stomach. His blood pressure stabilized after two pints of blood at 110/70.

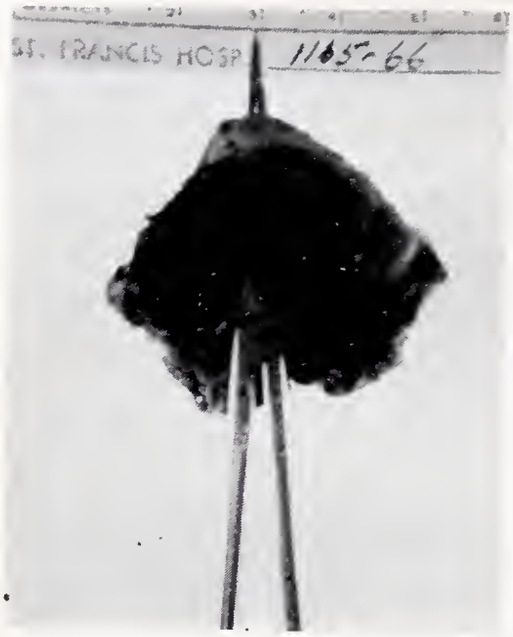



FIG. 1.—*Primary aorto-duodenal fistula showing large aortic opening.*




FIG. 2. — *Primary aorto duodenal fistula showing the smaller duodenal opening.*

Roentgenograms of his abdomen revealed calcification of the walls of the aorta but no abnormal widening. A limited upper GI series revealed a small sliding hiatal hernia but no ulcer. There was extrinsic pressure on the greater curvature of his lower stomach. The diagnosis of a primary aortoduodenal fistula due to rupture of an arteriosclerotic abdominal aortic aneurysm was suspected.

On April 27, under epidural-endotracheal anesthesia, the primary aortoduodenal fistula and arteriosclerotic abdominal aortic aneurysm were resected and a #19 dacron bifurcation graft inserted. The aneurysm had ruptured into the third portion of the duodenum. The fistula was funnel-shaped with the opening in the duodenum 1.2 cm in diameter and the opening in the aorta 2.5 cm. A wedge resection of the fistulous portion of the duodenum was done and the defect closed transversely. The aneurysm extended to the renal arteries, but a small cuff of aorta below the renal arteries permitted anastomosis to the synthetic graft. Endarterectomies of the common iliac arteries were also done to permit the anastomosis of the graft to the iliac arteries (Figs. 1 and 2).

Postoperatively, he did well except for a mild "stress psychosis" which was easily controlled with Librium. Pulses were now palpable not only on his right side but also on his left side. He was discharged in good condition on the fifteenth postoperative day. Follow-up for ten months has shown him to be in good condition.

## DISCUSSION

The rarity of primary aortoduodenal fistulas due to rupture of an arteriosclerotic abdominal aortic aneurysm is evidenced by the paucity of reports.[1, 2] The vast majority of the 50 cases in the literature have been discovered at autopsy.[2, 3] There have been only four instances of primary aortoduodenal fistulas that have been successfully treated. Only three of these were diagnosed preoperatively.[2, 4]

Of three thousand cases of abdominal aortic aneurysms and aortic occlusive diseases reported by DeBakey,[2] only two cases of primary aortoduodenal fistulas were described. In neither instance was a preoperative diagnosis made. Only one patient survived surgery.

Of 10,000 autopsies done at St. Vincent's Hospital[1] in New York, there were only four instances of primary aortoduodenal fistulas due to arteriosclerotic abdominal aortic aneurysms rupturing into the gastrointestinal tract.

Pain may not necessarily be a significant symptom in this entity. In this instance, the patient merely had some mild vague abdominal discomfort. Collapse with hypotension, nausea, vomiting, and unconsciousness were his most prominent symptoms.

It can be deduced from the patient's history that the erosion of the aneurysm had been occurring for some time. There is always the possibility that these fistulas are contaminated. Therefore, antibiotics are indicated in these situations. Voyles and Moretz[3] have described a case in which a Salmonella infection followed resection of the aneurysm and fistula.

The diagnosis should be entertained whenever gastrointestinal bleeding is associated with an abdominal aortic aneurysm.[4] Suspicion will enable these cases to be diagnosed preoperatively and a proper approach to the therapy of this entity undertaken.

This patient was fortunate in that he stopped bleeding after his initial episode. There was a plug of thrombus and arteriosclerotic debris in the funnel-shaped fistula that was sufficient to tamponade

the bleeding. It has been thought, however, that muscular spasm of the intestines is strong enough to overcome the aortic pressure and to stop the bleeding.[2] This appears to be possible, but somewhat questionable.

The aneurysm should be resected first without entering the duodenum. After proximal and distal control of the aorta is secured, the anterior portion of the aneurysm should be excised, the clots and debris removed, and control of the lumbar vessels secured with suture ligatures. Then the synthetic graft should be inserted. Reperitonealization should be carried out. This latter procedure is very important to avoid infection of the retroperitoneal area and to avoid a secondary aortoduodenal fistula. Only then should the primary aortoduodenal fistula be resected. Clamps should be placed on the duodenum above and below the fistula and a wedge resection should suffice for the duodenectomy. However, a primary end-to-end anastomosis can be done. It is probably easier to do a wedge resection of the duodenum because of the anatomical peculiarities of the third portion of the duodenum with its adherence and attachments to the posterior wall.

Postoperatively, these patients should all be placed on antibiotics as a precaution against infection. The possibility of contamination from aortoduodenal fistulas and ruptured aneurysms is great.[3, 5]


## SUMMARY

A case of primary aortoduodenal fistula due to a ruptured arteriosclerotic abdominal aortic aneurysm into the third portion of the duodenum with massive gastrointestinal tract hemorrhage is reported. This appears to be the fourth reported case to be diagnosed preoperatively and the fifth to be successfully treated.



1040 South King Street, 96814


## REFERENCES


1. Ferguson, M. J., and Arden, M. J.: Gastrointestinal hemorrhage secondary to rupture of aorta, Arch. of Int. Med. 117:133 (Jan.) 1966.
2. Garrett, H. E., Beall, A. C., Jordan, G. L., and DeBakey, M. E.: Surgical considerations of massive gastrointestinal tract hemorrhage caused by aortoduodenal fistula, Am. J. Surg. 105:6 (June) 1963.
3. Voyles, W. R., and Moretz, W. H.: Rupture of aortic aneurysms into gastrointestinal tract, Surgery 43:666 (Apr.) 1958.
4. Phillips, R. B., and Jarrell, S. E.: Arteriosclerotic aortic aneurysm with rupture into the duodenum:: report of a case with survival, Ann. Surg. 159:375 (Mar.) 1964.
5. Dinapoli, R. P., Schirger, A., and Kirklin, J. W.: Abdominal aortic aneurysm with bleeding into the gastrointestinal tract: report of case, Proc. Staff Meet. Mayo Clin. 37:354 (June) 1966.

*Improper treatment of acute otitis media invites masking of persistent infection and development of chronic otitis media and its meningitis, brain abscess, and lateral sinus thrombosis. A chronic draining ear may be the warning that this situation exists.*

# Intracranial Complications of Otitis Media In This Antibiotic Era

## Report of Cases

L. Q. PANG, M.D., *Honolulu*

• *The three major intracranial complications from an otitis media—meningitis, brain abscess, and lateral sinus thrombosis—are relatively uncommon in this antibiotic era. However, they do occur, and physicians still need to realize the potential dangers of otitis media. Moreover, modification of the inflammatory process by insufficient or ineffective antibiotic therapy often masks the potential complications and makes their diagnosis more difficult.*

IN THIS PAPER are presented cases of the serious intracranial complications arising from otitis media. The diagnosis, treatment, and possible prevention of these cases are discussed.

### OTITIC MENINGITIS

CASE 1. A 25-year-old Samoan man was first seen by me on December 18 with the complaint of a severe pain in his left ear and a headache. He had had a discharge from his left ear since childhood, but for two weeks it had increased in amount, and this had been followed by severe pain in the ear and a headache. He had been under care of his family physician for one week, but because of the severity of the symptoms and lack of response to treatment, he was referred to me.

The patient had been confined at St. Francis Hospital the previous October for a cerebral concussion and fracture of the left seventh rib, suffered when his car ran into a utility pole.

Examination revealed a well-developed and well-nourished Samoan who appeared ill, in pain, and very restless. The right eardrum was dull, and there was some granulation tissue and thick mucopurulent discharge from a perforation in the posterior inferior quadrant. A large polyp protruded into the left external auditory canal and a moderate amount of thick mucopurulent discharge under pressure was observed. His temperature was 99.6° F.

He was given a large dose of penicillin and an analgesic, and returned the next day, at which time an aural polyp was removed. However, because of the severity of the symptoms, he was admitted to St. Francis Hospital. His temperature and pulse on admission were 100° F. and 70 per minute. There was a noticeable stiffness of his neck, a positive Kernig's sign, and a slight rotary nystagmus on looking to the right. Laboratory work revealed a WBC of 10,900, with 94% polys; and RBC of 5.1 million. Urinalysis was normal.

One million units of Crysticillin intramuscularly twice daily, and sulfadimethoxine (Madribon) 2 gm on admission and then 0.5 gm twice daily were started. A neurological consultation was requested. However, because there was a long delay in the arrival of the neurosurgeon, it was decided to explore the mastoid.

Under local anesthesia, using 2% xylocaine and adrenalin, a Shambaugh endaural incision was made. The mastoid was densely sclerotic. A large amount of granulation tissue was found in the mastoid antrum. After removing the granulation tissue and exploring the attic, a large cholesteatoma was found. It extended into the attie of the middle ear and down to the tip of the mastoid. A radical mastoidectomy was done. An erosion of the tegmen was found in the attic area, and the dura was exposed for an area 1 em in diameter. It was inflamed but did not appear tense. The necrotic bone in the tegmen was removed until normal bone was encountered. The eardrum was densely bound down against the medial wall of the middle ear. The incus and stapes could not be visualized. The tympanomeatal flap from the external canal was brought over the facial ridge to obliterate the inferior portion of the mastoid cavity.

A spinal puncture done two days following surgery revealed cloudy spinal fluid. Laboratory analysis revealed 2,200 WBC per cu mm; 90% polys; 20 RBC per cu mm; protein, 130 mg %; sugar, 39 mg %; and chlorides, 677 mg %. The mastic was 2 4 4 4 4.

Culture of the ear revealed Bacillus proteus and a Streptococcus fecalis; they were sensitive to penicillin and chloromycetin.

Postoperatively, there was an immediate improvement in the patient's headache. The patient was given 1 million units of penicillin and 2.0 gm of sulfadiazine every four hours. The temperature gradually returned to normal. The stiffness of the neck gradually disappeared. As the symptoms improved, the dose of antibiotics was decreased. He was discharged completely well ten days after admission.

*Comments:* Prior to the antibiotics, most otogenic meningitis followed an acute otitis media (about 2 per cent), and recovery was relatively rare. Gray[1] was able to find only 27 reported cases of recovery in 37 years. Since penicillin, most of these cases, and especially those with a cholesteatoma, follow a chronic suppurative otitis media. Recovery is the rule if the disease is diagnosed early and treated adequately.

Headache is an ominous sign in acute otitis media, and even more so in chronic suppurative otitis media. These patients should always be checked for nuchal rigidity, and if it is present, a diagnostic spinal puncture should be done. If otitic meningitis must be differentiated from other intracranial complications, the cerebrospinal fluid findings are decisive. The findings of polymorphonuclear cells, pyogenic organisms, and reduced sugar and chlorides occur in meningitis. Sugar is usually not involved until the appearance of bacteria in the spinal fluid. The bacteria utilize sugar; hence, decreased sugar means bacterial invasion and aetivity. Return of sugar to normal is a favorable prognostic sign. In this case, the sugar was 39 mg % (normal 45-80), indicating that there was no bacterial invasion and therefore a good prognosis.

In the treatment, the meningitis always takes precedence over the otitis media. If surgical treatment to the ear or mastoid is required, the operation should be carried out as promptly as the condition of the patient will permit. Following an acute otitis media, a myringotomy or simple mastoidectomy may suffice. A radical mastoidectomy is usually required in a case following a chronic suppurative otitis media.

The antibiotics of choice are a combination of sulfadiazine orally, combined with large doses of penicillin by intramuscular injection. Sulfadiazine diffuses into the cerebrospinal fluid; penicillin does not, but operates through the blood stream. Repeated lumbar punctures were formerly used to reduce the cerebrospinal fluid pressure, but with antibiotics, the necessity of repeated spinal punctures is reduced, and they should be done only if there is evidenee of inereased spinal fluid pressure. Intrathecal injections of antibiotics should be used only if absolutely necessary.

### OTITIC BRAIN ABSCESS

Case 2. A 65-year-old Hawaiian woman complained of an earache and headache beginning two weeks prior to admission. She had had a recurrent discharge from her left ear for many years. She was treated by a physician with antibiotics and ear drops. Two days before admission, she felt worse, became confused, gradually lost the power of movement of the right arm and leg, and became aphasic. She was flown from Maui and admitted to St. Francis Hospital.

Examination revealed an obese, elderly lady who looked ill and was aphasic, although she could obey simple commands. There was a paresis involving the right arm, leg, and face, and anesthesia to pain and touch on the right side, but no nuchal rigidity. Funduscopic examination revealed arteriosclerotic changes but normal optic discs. There was a depressed corneal reflex in the right eye, a right upper motor neuron facial paralysis, and bilaterally depressed gag reflex. The right eardrum was normal. There was a small perforation in the attic of the left eardrum with a small amount of foul, white flaky discharge.

Laboratory work revealed 4,700 WBC, with 59% polys and 38% lymphocytes; RBC 4.5 million; and hemoglobin, 11.7%.

X-ray of the mastoids revealed dense sclerosis in both mastoids. Skull x-rays were normal. X-ray of the chest revealed a moderately enlarged heart and a slight widening of the aorta.

The neurological consultant felt that the patient had a possible cerebral thrombosis in the distribution of the left middle cerebral artery. However, in view of the ear infection, he felt that a space-occupying lesion such as a brain abscess had to be ruled out. Lumbar puncture revealed the following: O.P., 160 mm water; C.P., 100 mm water; clear and colorless fluid; WBC, 502 per cu mm; lymphocytes, 99%; polys, 1%; and RBC, 3 per cu mm. A smear revealed no organisms. A culture revealed no growth after 48 hours.

The patient was put on large doses of penicillin and sulfadiazine. However, her condition deteriorated, and she became stuporous. A carotid angiogram was done under local anesthesia. During the procedure, an emergency tracheotomy was done to relieve the respiratory obstruction.

The x-ray report was as follows: Left carotid arteriography in the anterior and lateral projections shows good filling of the left internal carotid artery and its branches. There is a marked superior and medial displacement of the left middle cerebral artery, indicative of a mass lesion in the left temporal area, compatible with a clinical impression of a brain abscess.

The patient was then taken to surgery, and a left posterior temporal craniotomy and aspiration of the abscess was done under local anesthesia through a vertical linear incision 2 cm beyond the external auditory meatus. The burr hole was done with a Hudson drill and enlarged with Lexsel bone forceps. The dura was found to be tight and was cauterized and opened with a No. 11 Bard Parker blade. A ventricular needle was passed into the posterior temporal, middle temporal, and finally into the anterior temporal area, where the abscess was encountered. Ten cc of foul-smelling purulent material was aspirated. The needle was removed and replaced with a flexible Scott needle placed in the abscess cavity. The abscess cavity was then irrigated with saline and 6 million units of penicillin. The pressure was immediately relieved, as noted by the pulsation of the dura and by the fact that the patient became more reactive. After irrigation of the abscess cavity, 15 cc of Renografin mixed with saline was instilled in the abscess cavity, and an x-ray taken. It showed a 6 x 4 cm abscess cavity which appeared to be well circumscribed. A small inferior extension about 1 cm in diameter, continuous with the main abscess cavity, extended almost to the level of the base of the skull. The abscess cavity was situated about midway between the anterior and posterior portions and level with the petrous pyramids, and approximately midway between the midline and the outer table of the skull.

Postoperatively, daily irrigation of the abscess cavity was done. The patient became much more alert after surgery and was able to speak 24 hours later. On the third day, the patient pulled out the drainage tube to the abscess cavity. The tracheotomy tube was removed three days following surgery. On the fourth day following surgery, a radical mastoidectomy was done under local anesthesia. A large cholesteatoma was found filling the mastoid antrum and attic of the middle ear and extending down medially under the facial nerve to the mastoid tip. An area of erosion 1 cm in diameter was found in the tegmen tympani. The necrotic bone was removed until normal bone was encountered. There was a slight herniation to the dura, which appeared to be rather tense. However, it was not opened. The incus was found to be bound down in the dense granulation tissue and was removed. The drum was intact except for the small perforation in the Shrapnell's membrane. The cholesteatomatous matrix, which extended under the facial nerve, was left intact. The tympanomeatal flap and skin from the external canal were brought over the facial ridge to obliterate the lower portion of the mastoid cavity.

The culture of the ear revealed a Pseudomonas species, sensitive to penicillin, neomycin, mandelamine, Chloromycetin, and streptomycin. The patient withstood the procedure well and was discharged from the hospital 18 days after admission. She has been well since, although she has developed a mild stenosis of the external canal.

*Comments:* Otitic brain abscess most commonly follows an acute exacerbation of a chronic purulent otitis media. Cholesteatoma as a part of such chronic otitis is a very common etiologic factor, present in at least 60 per cent of cases.[2] Cholesteatoma causes pressure defects in the bony walls of the attic of the middle ear and the mastoid antrum. It seriously interferes with the free drainage of pus, which can readily affect the dura, the lateral sinus, and the labyrinth; from these, suppuration may enter the brain. The presence of the headache in a chronic suppurative otitis media is a very ominous sign and should put the otologist on guard. This is especially significant when accompanied by cerebral dysfunction.

In the diagnosis, electroencephalography is valuable. It is abnormal in 75 per cent of the cases; and in 50 per cent, it gives accurate localization.[3] A spinal puncture should not be done when there is increased intracranial pressure, as there is a risk of herniation of the brain stem into the foramen magnum. A spinal tap should not be done when

there is severe headache, stupor, coma, or papilledema unless there are facilities for immediate and adequate neurosurgical intervention.

There is some question as to which is the better method of draining a brain abscess of otitic origin. It is now generally agreed[3] that a transarachnoid approach to the abscess by a burr hole or craniotomy through a clean area away from the mastoid cavity is preferable. The chief difficulty of this approach is the control of hemorrhage, especially constant oozing and bleeding from larger vessels. However, bleeding from the scalp incision can be controlled by the use of skin clips and bone wax, and the bleeding vessels in the dura in the brain surface can be sealed by electrocoagulation, sutures, or skin clips. It is usually done best under local anesthesia.

The abscess cavity is treated by repeated aspiration and instillation of penicillin. However, in cases where the temporal lobe abscess has a demonstrable stalk and lies near the dura, it can be drained easily through the mastoidectomy approach. After removal of the cholesteatoma and the necrotic bone, the floor of the abscess may be excised to permit marsupialization and complete evacuation of the contents. The area in the mastoid cavity is then packed with Gelfoam.

After the abscess has been treated and is under control, the focus of infection in the ear must be eradicated. In a case following an acute otitis media, a simple mastoidectomy may be necessary. In one following a chronic suppurative otitis media, a radical mastoidectomy must be done to eradicate the disease and cholesteatoma, if present.

An otogenic brain abscess is a serious disease and still carries a mortality of 20 per cent. In 50 per cent of adults, recovery is followed in six to twelve months by epileptic seizures.[3] This does not occur in children under ten years of age.

### LATERAL SINUS THROMBOSIS

CASE 3. A 23-year-old Hawaiian-Chinese man was first seen on April 10, 1952, with the complaint of a throbbing pain in the left ear for three days. On the day before he was seen, he developed chills and fever, a severe headache, and a noticeable increase in the amount of discharge from his left ear. This aural discharge had been present for ten years.

Examination revealed a well-developed and well-nourished man who looked acutely ill. There was some pulsating discharge from the left ear, a severe drooping of the posterior superior canal wall, and a marked tenderness in the mastoid antrum and beneath the mastoid tip along the upper portion of the sternomastoid muscle. He was admitted to St. Francis Hospital with the diagnosis of an acute left mastoiditis and a possible lateral sinus thrombosis.

On admission, the temperature was 101.6° F.; WBC 16,500 with 92% polys; urinalysis was negative. X-rays of the mastoids revealed the left mastoid to be well pneumatized with a large area in which the cell outlines were indistinct and generally hazy. The sinus plate was faintly visualized. The right mastoid was well pneumatized and appeared normal.

At surgery, a left simple mastoidectomy was performed. As soon as the mastoid cortex was opened, a large amount of thick, creamy pus oozed out under pressure. The thick, coalescent, broken-down mastoid cells were removed all the way down to the tip. Much granulation tissue covered the entire lateral sinus plate, and a small area of erosion of the plate was found. The sinus plate was removed from the knee to the jugular bulb, exposing the lateral sinus, which appeared creamy yellow and much thickened. A vertical incision was made into the wall of the sinus, but no bleeding was encountered. A forceps was introduced upward, and a large, long thrombus was removed. This was followed by a sudden gush of blood from the upper end of the sinus. A gauze pack was introduced between the bone and the sinus to control the bleeding. The lower end of the sinus was explored, and a small thrombus was extracted. This was followed by a small retrograde flow of blood. The entire mastoid cavity was packed with iodoform gauze and left open. A mastoid dressing was applied. No ligation of the internal jugular vein was performed.

Postoperatively, the large doses of penicillin and Aureomycin were continued. The septic fever returned to normal within two days. The culture of the ear revealed a hemolytic Staphylococcus albus and Pseudomonas. The blood culture was negative after 72 hours. Six days after the initial mastoidectomy, he was returned to surgery. The gauze packs in the mastoid cavity were gently removed without any bleeding from the lateral sinus. A secondary closure of the wound was done. He was discharged from the hospital on April 24, 13 days after admission.

The patient continued to have a purulent drainage from his left ear. He was readmitted to the hospital on May 21 for surgery. Through an endaural approach, the mastoid was explored. There were some remaining zygomatic cells which had not been exenterated. There was much granulation tissue in the mastoid antrum and attic of the middle ear. After removal of the granulation tissue, a cholesteatoma was found in the attic. The simple mastoidectomy was converted into a radical

mastoidectomy, and the cholesteatoma was removed. Only remnants of the malleus and incus were found; they were removed. He was discharged four days later. The ear has remained dry.

*Comments:* Involvement of the lateral sinus is the commonest of the major intracranial complications and constitutes 50 per cent of them.[3] Most of the cases result from a chronic suppurative otitis media and cholesteatoma. However, in infants and children, it more commonly results as a complication of an acute otitis media which has been "masked" by insufficient or improper antibiotic therapy.

Prior to antibiotics, the classical triad of symptoms consisted of chills and fever occurring during the course of an otitis media, a positive blood culture, and a positive Tobey-Arey test. However, since the advent of antibiotics, the symptoms have been "masked" so that the classical picture is very seldom seen. The otologist must be on guard for this complication in any case of acute otitis media, where the patient is not doing as well as might be expected from the minimal physical signs found. Irritability on the part of a child, or a tendency to lie about or fall asleep at frequent intervals, should alert the clinician. These cases should be watched carefully for a sagging of the posterior superior canal wall and should be followed with x-ray studies of the mastoids.

In this case, the symptoms were rather typical (they still are in cases following a chronic suppurative otitis media, in contradistinction to one following a "masked" acute otitis media). A Tobey-Arey test was not performed, although in this case it would have been positive. The internal jugular vein was not ligated. Most otologists now feel that this is not necessary.

The prognosis in this condition is good, provided it is diagnosed early and treated adequately with antibiotic therapy and the appropriate surgical procedure. Delay in diagnosis may result in the spread of the thrombosis and a secondary meningitis and brain abscess with an increase in the morbidity and mortality up to 40 per cent.

## GENERAL COMMENTS

All three cases discussed resulted from a chronic suppurative otitis media which was associated with a cholesteatoma. Ruggles[2] found that, in the cases of chronic suppurative otitis media that were operated on, a cholesteatoma was found in 60 per cent. This has been my experience. Contrary to the old teachings, a cholesteatoma may be found even in a case of central perforation of the eardrum.

It seems relevant to discuss the treatment of an acute otitis media. There is a tendency among physicians to treat an acute otitis media with ear drops and "a shot of penicillin" to take care of the infection. Sometimes, though oftentimes not, an oral antibiotic is prescribed as a follow-up, and often the patient is not advised to return for follow-up observation. The patient may or may not take the medication, since the acute infection and symptoms are blunted. The smoldering infection, however, goes on, oftentimes to a near-disastrous result. Insufficient and inefficient antibiotic therapy leads to chronicity and complications. Often, however, it leads to a secretory otitis media with the accumulation of a mucoid or mucopurulent material in the middle ear, with a resulting conductive deafness.

In the treatment of an acute otitis media, the antibiotic therapy should be adequate and should be continued for at least one week or until all subjective and objective symptoms are controlled. The best method of administering penicillin in an otitis media is by the intramuscular route. A myringotomy should be performed if necessary. The patients should be followed and should not be discharged until the eardrum has returned to normal.

The other point concerns the chronic suppurative otitis media. There is an erroneous impression among lay people and even some physicians that a chronic discharge from the ear is innocuous. While fully half of such cases are the "nondangerous type," an equally large number are the "dangerous type," which is associated with a cholesteatoma, with all its inherent potential for intracranial mischief. All cases of chronic draining ears should have a careful otologic check-up. In this era of antibiotics and improved microsurgery of the ear, a tympanoplasty can be done to eradicate the infection and to preserve or improve upon the residual hearing in the greater percentage of cases. At least, the potential dangers should be eradicated.

## SUMMARY

A case each of the three most common and serious intracranial complications from otitis media is presented, together with comments relative to their early diagnosis and treatment. A plea is made for adequate therapy of acute otitis media to prevent chronicity and masking of the infection. A plea is also made for the proper management of chronic suppurative otitis media to eradicate infection and potential danger and to preserve or improve hearing by microsurgical techniques. ■

1374 Nuuanu Ave., 96817

## REFERENCES

1. Gray, Harry J.: Streptococcic meningitis—report of a case with recovery, JAMA 131:92-95 (July) 1936.
2. Ruggles, R. L., and Cassady, Charles: Otitic temporal lobe abscesses, Laryngoscope 75:1259-1267 (Aug.) 1965.
3. Mawson, S. R.: Diseases of the ear, The Williams and Wilkins Co., 1963.

*Two case reports of squamous cell carcinoma illustrate satisfactory results after simple excision.*

# Carcinoma of the Conjunctiva

HERBERT G. PANG, M.D., *Honolulu*

• *Frank squamous cell or basal cell carcinomas may develop from leukoplakia, intraepithelial epitheliomas, and papillomas of the conjunctiva.*[1, 2] *Epidermization usually extends well beyond the secondary lesion (epithelioma or carcinoma), and it is therefore a potential focus for recurrence if it is not excised with the main lesion.*[2, 3]

SQUAMOUS CELL CARCINOMAS of the conjunctiva are much more common (about ten times) than basal cell carcinomas of the conjunctiva.[1, 3, 4, 5, 6] They usually arise at the limbus and spread to the cornea and adjacent bulbar conjunctiva, although they may arise primarily in the bulbar or palpebral conjunctiva.

## CLINICAL PICTURE

Carcinoma of the conjunctiva usually arises at the limbus and spreads to the cornea and adjacent bulbar conjunctiva, although it may arise primarily in the bulbar or palpebral conjunctiva. A limbal carcinoma may invade the sclera and, much more rarely, the cornea. The tumor may even extend through the sclera and show intraocular invasion, but this is an extremely rare occurrence.

Sometimes a papilloma is the forerunner of squamous cell carcinoma, and in the transition stage, it may be difficult even on histologic examination to state whether the lesion is a papilloma or an early squamous cell carcinoma.

The papilloma[3] demonstrating transition to malignancy usually shows evidence of growth, acquires vascularity as shown by its change to pinkish color and frequent association with feeder vessels. It may or may not become ulcerated.

Leukoplakia occurs less frequently on the conjunctiva. It appears as a slightly elevated white plaque which is easily overlooked and is sometimes mistaken for pinguecula. A leukoplakia lesion is white and superficial, whereas a pinguecula is yellow and subepithelial. The transition from benign leukoplakia[3] to carcinoma can be recognized clinically by an increase in vascularization and inflammatory reaction. The tumor loses the dead whiteness of leukoplakia and acquires a characteristic fleshy hue. Then typical large feeder vessels become manifest. These feeder vessels usually consist of a single dilated artery with an occasional accompanying vein. Most typically, they arise in the inferior temporal quadrant.

## TREATMENT

The treatment of squamous cell carcinomas depends largely on the site of the lesion and its size.[1, 3, 7] When the lesion is well localized, excision is in order. If the tumor has involved the limbus, it is well to apply heat cautery at the sulcus between the cornea and sclera after the excision, for it is there that excision may not reach all tumor tissue. When the cornea is involved, it must be remembered that Bowman's membrane offers considerable resistance to growth, and therefore the tumor may advance well into the pupillary area of the cornea without involving the stroma. This fact makes excision possible in some cases in which the growth seems to be quite far advanced.

Some authors have pointed out that radical treatment such as enucleation is seldom indicated.[2, 3] They have advised simple excision. If, at the time of operation, there is evidence that the tumor has shown invasive tendencies in the sclera,[1, 8] enucleation may be necessary, or an excision can

be supplemented with radiation in the form of the Ridley type of strontium application or of low-voltage x-ray. Some ophthalmologists have advocated superficial lamella keratectomy or sclerectomy.

The tumors occurring at the limbus seem to have the least tendency of all to metastasize to the regional lymph nodes.[4] Those which occur further away in the bulbar conjunctiva or the fornix or in the lid proper have a greater tendency to metastasize to the regional lymph nodes. This was borne out in the study of squamous cell carcinoma in cattle as reported by Russell and his associates.[9]

If the tumor recurs and it is not too widespread or too deeply invasive, it can at times be excised a second time. If it recurs following reasonable care in excision or invades the cornea or sclera deeply, even into the globe, enucleation must be performed, and all diseased conjunctiva must of necessity be removed.

Reese's experience with treating carcinoma of the conjunctiva by radiation has not been entirely satisfactory because there is a tendency toward necrosis of the underlying sclera which may lead to an intractable ulcer, iridocyclitis, and even secondary glaucoma.[10]

Ash and Wilder concluded that local excision of squamous cell carcinoma of the conjunctiva is adequate, provided enucleation is undertaken if recurrences persist.[2] They advised against pre- or postoperative irradiation.

## TWO CASE REPORTS

*Case I:* A Hawaiian-Caucasian man, aged 69, was first seen on March 23 with a complaint of pain in the left eye of several days' duration. Examination showed that vision was good in both eyes. In the left eye, there was seen nasally a foaming raised area next to the limbus. It resembled a Bitot's spot. The lesion was elevated, and recommendation for excision was made to the patient. The lesion was excised on April 12. Pathological report by Dr. Raid Chappell at St. Francis Hospital is as follows: Grossly, this specimen is a triangular piece of grey and brown tissue, measuring 7 mm in greatest diameter. Microscopic section shows conjunctiva epithelium in which there is a very marked and irregular thickening due to hyperplasia of malignant type of its component squamous cell. Mitotic figures are exceedingly rare, but the neoplasm evidences itself by an absent or indeterminate line over the subjacent stroma, nuclear variations in size and shape with many prominent nucleoli and an active inflammatory reaction in the subjacent stroma. The latter is usually a sign of host resistance to tumor.

Diagnosis: Squamous cell carcinoma, Grade I, of conjunctiva.

The patient was followed at yearly intervals, and when last seen, almost five years after surgery, no recurrence was seen.

*Case II:* A 41-year-old Filipino man was first seen on July 8 when he complained of some itching in his right eye of one month's duration. Examination of the right eye revcaled a slight polypoid pigmented growth of the conjunctiva, 2 mm away from the nasal limbus, measuring 2 mm in size. There was some vascularization in the middle of this lesion. Growth was excised on July 19. Microscopic report shows conjunctiva with an area of atypical hyperplasia in which there is a dyskeratosis of cells and a disorganized pattern. Mitotic figures are not apparent, but the degree of cellular atypism leads one to believe that lesion to be of low-grade malignancy.

Diagnosis: In situ squamous cell carcinoma, Grade I-II, of conjunctiva.

## SUMMARY AND CONCLUSIONS

Squamous cell carcinoma of the conjunctiva is ten times more common than basal cell carcinoma. The lesion can bc recognized as being raised, shows a pinkish color, and is frequently associated with feeder vessels. The treatment for carcinoma of the conjunctiva is simple wide excision. If recurrences do occur and are not too widespread or deeply invasive, these can at times be excised again. If the carcinoma recurs following reasonable care in excising or invades the cornea or sclera deeply, even into the globe itself, enucleation must be performed. In some cases, recurrences are treated by excision and beta radiation or x-ray, but one must be careful that the complications of radiation are not encountered. This is a report of two cases of squamous cell carcinomas which were treated by simple excision. Five years postoperatively no recurrences have been observed.

1374 Nuuanu Ave., 96817

## REFERENCES

1. Reese, A.: Tumors of the eye, 2d Ed., pp. 23-28, Hoeber, 1963.
2. Ash, J. E., and Wilder, Helen C.: Epithelial tumors of the limbus, Amer. J. Ophth. 25:926-932 (Aug.) 1942.
3. Swan, Kenneth C., Emmens, Thomas H., and Christiansen, Leonard: Experiences with tumors of the limbus, Trans. Amer. Acad. Ophthal. Otolaryng. 52:458-469 (May-June) 1948.
4. Reeh, Merril J.: Treatment of lid and epibulbar tumors, p. 86, Charles C. Thomas, 1963.
5. Fox, Sydney: Ophthalmic plastic surgery, 3rd Ed., p. 399, Grune and Stratton, 1963.
6. Harris, Ronald H.: Cancerous and precancerous lesion of the conjunctiva and cornea, Virginia Med. Monthly 86:138-143 (Mar.) 1959.
7. Samuels, Bernard: Tumors of the conjunctiva and lids, Arch. Ophth. 26:789-796 (Nov.) 1941.
8. Hogan and Zimmerman: Ophthalmic pathology, 2d Ed., p. 262, W. B. Saunders Co., 1962.
9. Russell, William O., and Loquvam, George S.: Squamous carcinoma of the conjunctiva and cornea of bovines, Amer. J. Path. 41:805 (May) 1956.
10. Jones, Ira, and Reiss, A. B.: Focal scleral necrosis, Arch. Ophth. 49:633-636 (June) 1953.

*Radiosensitivity aids in the*

*treatment of this childhood tumor.*

# Medulloblastoma

## A Case Report

WILLIAM W. T. WON, M.D., *Honolulu*

• *One of the more malignant of the posterior fossa tumors, especially in children, is the medulloblastoma. It makes up about 18 per cent of all brain tumors found in this age group.*[1] *Though rarely resectable, it may yield to radiation therapy for long periods.*

ONLY ONE medulloblastoma is recorded in the files of the St. Francis Hospital since 1955. Since this tumor is uncommon here, it is felt that a case of medulloblastoma in a teen-aged boy would be of interest.

CASE REPORT

A 14-year-old boy was admitted to St. Francis Hospital because of vomiting and unsteady gait for two or three months prior to admission. He had mild and occasional headaches, and vomited several times, leading his parents to think that he had the "flu" and treat him accordingly. However, his symptoms did not clear up, but steadily worsened. When he began to veer to the left side when walking, he was brought to his family doctor. He was then referred for neurosurgical consultation.

Neurological examination revealed a well-developed, thin Chinese youth in no acute distress. The gait was ataxic and wide-based, and he was unable to do tandem walking. Deep tendon reflexes were hypoactive in the arms and hyperactive in the legs. Babinski's sign was not elicited. Sensory examination was entirely within normal limits. Ophthalmoscopy revealed bilateral papilledema, with engorged veins, but no hemorrhages or exudates. There was bilateral nystagmus on lateral gaze to either direction. The visual fields were intact, and there was a diplopia on right lateral gaze. The remainder of the cranial nerves were within normal limits. The patient was alert, oriented, somewhat sullen, with little spontaneous activity. He did not complain of much headache.

On the morning following admission, a ventriculogram was done. X-rays revealed symmetrical ventricular dilatation, and auto-tomograms of the fourth ventricle revealed the presence of a large intraventricular tumor obstructing the outlet of the fourth ventricle.

A suboccipital craniotomy was performed immediately following the air study. On opening the dura, metastatic implants were seen on the surface of the cerebellar hemispheres, and the tonsils were seen to be herniated down below the level of C-1. The foramen of Magendie was plugged with tumor. This portion of the tumor was removed, opening the fourth ventricle. The tumor filled all of the ventricle and was removed in one piece. This opened up the aqueduct, whereupon there was a

free flow of cerebrospinal fluid from above. A metastatic implant on the floor of the fourth ventricle was not disturbed. The wound was closed in routine fashion, leaving the dura open. None of the metastatic implants was removed. Following the operation the patient seemed to be brighter, and the papilledema began to subside. He was sent for radiotherapy one week after operation.

The patient had a benign postoperative course and tolerated radiotherapy well. A year after surgery, he is attending school on a schedule that excuses him only from physical education classes.

## DISCUSSION

Since 1925 when Bailey and Cushing classified this specific tumor entity, it has been the consensus that its total removal is impossible.[1] In the 1930's, Cushing reported that radiotherapy was helpful in slowing down the progress of the tumor, and that surgical decompression of the ventricular system, with subsequent x-ray therapy, would afford patients the longest survival times. This view has been substantiated by numerous reports in the literature.[2]

More recently, reports have been appearing with survivals of five or more years, and it seems that the neurosurgeon can approach these tumors now with more optimism.[3, 4]

The medulloblastoma is a highly malignant tumor, but it is also highly radiosensitive.[5] At surgery, cutting through tumor may cause seeding of the tumor cells through the cerebrospinal fluid, and this is believed to be one of the causes of metastases developing along the spinal canal following surgery. For this reason it is felt that the entire cerebrospinal axis should be irradiated in the postoperative period. The prognosis seems to be best in older children and especially in postpubertal patients treated in this fashion.[5]

Vomiting is a common symptom of childhood. Headaches are also rather prevalent among complaints of older children. However, when a child has a combination of both, with "dizziness," the physician should be alerted to consider an intracranial space-occupying lesion. The "dizziness" may actually be an unsteady gait, and the parents will say the child walks as if he were drunk.

Once the diagnosis is made of increased intracranial pressure, then all efforts are directed to delineating the cause of the obstruction. When this has been determined, treatment of the condition is carried out to prevent further brain damage and herniation of the brain. Surgical treatment is mainly aimed at unblocking the cerebrospinal fluid pathways. If the tissue report on fresh examination is returned as benign, then total tumor removal is attempted. If it is reported as malignant, the operation is terminated after establishment of adequate cerebrospinal fluid flow and the wound closed.

Postoperative radiotherapy is a necessary and important part of the treatment of these tumors, and is instituted as soon as possible after the skin sutures are removed. It is necessary to irradiate the whole cerebrospinal axis.

Patients responding well to this regimen can look forward to a long period of normal or near-normal life. ■

1374 Nuuanu Ave., 96817

## REFERENCES

1. Matson, D. D.: Benign intracranial tumors of childhood, New Eng. J. Med. 259:330-337 (Aug. 14) 1958.
2. Smith, R. A., Lampe, I., and Kahn, E. A.: The prognosis of medulloblastoma in childhood, J. Neurosurg. 18:91-97 (Jan.) 1961.
3. Ingraham, F. D., and Bailey, O. T.: Cerebellar medulloblastoma with verification nineteen years after onset of symptoms, J. Neurosurg. 1:252 (July) 1944.
4. Penfield, W., and Feindel, W.: Medulloblastoma of cerebellum with survival for seventeen years, Arch. Neurol. Psychiat. 57:481 (Apr.) 1947.
5. Taveras, J. M.: Radiotherapy of brain tumors, Clin. Neurosurg. 7:200-213, 1959.

*Insufficient blood supply to the leg*

*can be a correctible disorder.*

# Femoropopliteal Artery Reconstruction

EDWARD K. LAU, M.D., and RICHARD K. S. PANG, M.D., *Honolulu*

• *Individuals with a history of progressive claudication, rest pain, ischemic ulceration, or early gangrene involving one or more toes, supported by clinical findings of a weak femoral pulse and absence of popliteal and distal pulses, are candidates for arteriographic evaluation. As patterns of occlusion may vary in different individuals, roentgenograms of the aorto-iliac, femoropopliteal, and distal popliteal-tibial vessels should be available for interpretation before any reconstruction procedure can be applied. We have routinely included the aorto-iliac vessels in our studies for the reason that if associated lesions are found in the aorta or iliac vessels, these can be corrected before an attempt is made to correct the femoropopliteal lesion.*

IN SITU THROMBOSIS of an arterial graft is more likely to occur if the volume is insufficient or the flow rate too slow; then, no matter what procedure or type of material is used for the bypass, the revascularization procedure is doomed to failure.

To restore distal circulation in patients with occlusive disease of the femoral and popliteal arteries, three basic techniques may be applicable: (1) stimulation of collateral circulation by lumbar sympathectomy, (2) direct removal of the occlusive disease by endarterectomy, and (3) bypass of the occlusive disease area.

## THREE BASIC TECHNIQUES

Lumbar sympathectomy is indicated only in poor-risk patients with advanced or diffused atherosclerotic disease involving the distal branches of the popliteal artery. Vascular reconstruction in these cases is usually not applicable, and sympathectomy is all that can be offered to improve their vascular status. Sympathectomy combined with limited endarterectomy or angioplastic repair offers the best chance of healing in individuals with trophic changes of the skin of the leg.

Limited endarterectomy, with or without a vein patch graft reconstruction, is advisable only if the disease is localized to a short segment of the artery. However, this method still remains very popular in many clinics for long segments of occlusion.[1] In general, the bypass principle has proved to be the most effective means of vascular reconstruction, although it is frequently combined with other techniques, such as limited endarterectomy or angioplastic repair with a patch graft. In the presence of aortoiliac and superficial femoral artery occlusion, perfusing the deep femoral artery (profunda femoris) alone through an aortofemoral bypass is sufficient in many instances to give relief from rest pain and claudication.

Patients with a poor runoff at the popliteal bifurcation as shown on arteriogram are explored and patency determined in relation to a limited endarterectomy or patch graft procedure to open the lumen of at least one of the three terminal branches to the lower leg in order to anastomose a graft to it to restore circulation. That alone may be sufficient to revascularize that area and give relief from ischemic pain. However, this procedure should be reserved for patients with localized disease, and the salvage of the extremity hinges upon patency and successful reconstruction. If restoration of function is unsuccessful, lumbar sympathectomy or amputation should be considered.

## MATERIAL AND METHODS

For bypassing atherosclerotic lesions distal to the common femoral artery, synthetic or autogenous vein grafts are commonly used. In the aorta and common iliac arteries, where the lumen is large, the volume and flow rate through the graft are adequate, and there is no joint space to cross, synthetic substitutes are satisfactory.

Dacron prostheses for arterial substitutes below the groin continue to be generally unsatisfactory, especially if placed across the joint of the knee. Such prostheses tend to occlude in a relatively short time compared to the autogenous saphenous vein graft. Woven teflon bypass grafts as a vascular substitute also have generally been unsatisfactory and are being used less and less. Poor results have been reported in the studies made by Edwards[2] and Wosolowski,[3] the latter reporting that differences in porosity between the knitted dacron and the woven teflon may be the cause of early thrombosis and poor results in teflon grafts. Cannon,[4] Barker,[5] and Spencer[6] also report a high incidence of late occlusion with dacron prostheses and autogenous vein grafts, and have returned to thromboendarterectomy with vein patch graft to enlarge the lumen of small arteries as their method of choice for femoropopliteal artery reconstruction.

The autogenous saphenous vein as a bypass graft, as advocated by Linton and Darling,[7] has been in our hands most gratifying and encouraging. We have applied this technique with 10 of 21 patients with moderate to severe atherosclerotic femoral and popliteal artery disease.

## COMPLICATIONS

In these ten patients, 14 vein graft bypasses were done with two instances of late postoperative thrombosis, or a patency rate of 86 percent. The most frequent postoperative complication of the extremity was related to edema, the cause of which was not ascertained in most instances and which usually disappeared within a few weeks. Wound infection and hematoma formation were encountered in several cases, but fortunately did not present any serious problems, such as infection of the graft or massive hemorrhage. Infection is a serious hazard to life as well as limb in all arterial surgery. Should infection be present, the graft prosthesis should be removed to reduce the risk of massive hemorrhage. Postoperative antibiotic therapy appears to be effective in controlling wound infection.

Immediate thrombosis of the graft was encountered in one instance due to twisting and angulation of the graft, necessitating revision of our technique. On one occasion the length of the distal saphenous vein was too short and the diameter too small for proximal anastomosis, requiring removal of a larger piece of vein from the opposite thigh and conjunction to permit more satisfactory end-to-side anastomosis.

Generalized oozing around the incision occurred in one of our early cases, due to excessive use of local heparin. We have found heparin useful locally and continue to use small doses intermittently to distal peripheral arteries, not to exceed 50 to 60 mg/100 ml. Systemic heparinization or long-term anticoagulant therapy during and after surgery is used only if patients are under such therapy for cardiac or cerebrovascular disease.

## EARLY AND LATE FAILURES

Early failures may be due to the technique or to inadequate proximal inflow to the graft. Intimal flap dissection in an endarterectomized segment is a frequent cause of early thrombosis and occlusion of the distal vessels. The importance of implantation of the graft without twisting, and of meticulous suturing of the edges of the vein, to inflict minimal trauma to the artery, cannot be overemphasized.

Late failures may be due to uncorrected proximal disease or to the disease process distally. It is generally accepted that late failures of 50 percent or more are to be expected when using plastic prostheses below the knee joint,[8] and 70 percent success rate when using autogenous saphenous vein bypass graft.[7] As noted earlier, with the use of dacron prostheses, loss of flexibility, kinking, and false aneurysmal formation may result.

Diabetes appears to affect the success rate; the thrombosis rate in diabetic patients was 50 per cent compared to 33 per cent in nondiabetics. Late failures may be due to poor inflow of blood from the iliac artery with associated poor outflow of blood through the prosthesis, causing early in situ thrombosis; therefore, in combined lesions the inflow tract lesion should be corrected first.

We have twice tried autogenous saphenous vein from which the valves have been removed for bypass, as recommended by Hall;[9] both cases thrombosed in a relatively short time. Connolly[10] considers this operation to have several advantages over removal and reversal of the vein as a shunt; these include speed of operation, decrease of trauma and vasoconstriction, elimination of vein rotation problems, and intact viability of vein graft, resulting in an expected lowered incidence of subsequent thrombosis.

## SUMMARY

A series of 21 consecutive patients with femoropopliteal atherosclerotic occlusive disease treated by combined endarterectomy and vein patch graft or autogenous saphenous vein bypass graft is reported. In two instances aortoiliofemoral bypass was carried out first because of the presence of significant proximal occlusive disease. There were no operative deaths. Four patients had bilateral vein bypasses. Early occlusion was noted in one case and late occlusion in five cases. Of these five late cases only two followed autogenous vein bypasses, giving a long-term patency rate of 86 per

TABLE 1.—*Results of femoropopliteal artery repair.*

| CASE | AGE (Yr.) | MAIN SYMPTOMS | DISTAL ANASTOMOSIS ABOVE (A) OR BELOW KNEE (B) | REPAIR | DURATION OF FOLLOW UP (Mo.) | PATENCY |
|---|---|---|---|---|---|---|
| 1 | 69 | Rest pain. Claudication | A | Endarterectomy and sympathectomy | 52 | Patent |
| 2 | 59 | Claudication | A | Freeing of adhesions and kink | 44 | Patent |
| 3 | 51 | Claudication | A | Endarterectomy and angioplasty. Left sympathectomy | 41 | Patent |
| 4 | 39 | Gangrene of toe | A | Dacron bypass Sympathectomy | 53 | Thrombosed (6 mo.); Amp. of toe |
| 5 | 62 | Claudication | A | Thrombectomy Vein patch angioplasty | 36 | Patent |
| 6 | 65 | Rest pain | B | Endarterectomy Vein patch angioplasty | 30 | Patent |
| 7 | 59 | Rest pain. Claudication | A | Saphenous vein bypass Sympathectomy | 12 | Thrombosed amputation A. K. |
| 8 | 48 | Claudication | A | Bilateral saphenous vein bypass | 18 | Patent |
| 9 | 55 | Pain | A | Thrombectomy with vein patch graft | 18 | Patent |
| 10 | 53 | Claudication | A | Aorto-femoral bypass, then bilateral saphenous vein bypass | 17 | Patent |
| 11 | 65 | Claudication | B | Saphenous vein bypass with patch graft to post tibial | 12 | Thrombosed (6 mo.); Reoperation |
| 12 | 60 | Claudication | A | Saphenous vein bypass, bilateral | 48 | Patent |
| 13 | 68 | Claudication | A | Saphenous vein bypass | 18 | Patent |
| 14 | 56 | Claudication | B | Saphenous vein bypass | 17 | Patent |
| 15 | 57 | Claudication and ulcer | B | Saphenous vein bypass | 15 | Patent Ulcer healed |
| 16 | 74 | Rest pain. Claudication | B | In situ vein graft | 8 | Thrombosed; amputation |
| 17 | 42 | Claudication | A | Aorto-femoral bypass, then bilateral saphenous vein bypass | 39 | Patent |
| | | | | | 4 | Patent |
| 18 | 56 | Rest pains | A | Thromboembolectomy | 5 | Patent |
| 19 | 66 | Rest pains | A | Embolectomy with patch graft | 24 | Patent |
| 20 | 65 | Claudication | A | In situ vein graft | 12 | Thrombosed |
| 21 | 55 | Claudication | A | Saphenous vein bypass | 37 | Patent |

cent in a total of 14 attempts. Anticoagulant therapy and sympathectomy were not used routinely. Early failures are usually due to technical errors and late failures to improper evaluation of proximal and distal occlusive disease and the failure to carry out reconstruction to an appropriate level to insure adequate inflow and outflow rates.

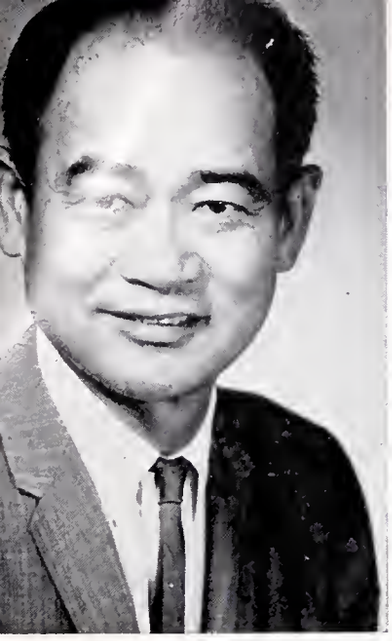
Arteriograms before and after operation help to locate residual luminal irregularities and to prevent changes that may precipitate later difficulties and failures.

Long-term results of arterial reconstruction for occlusive disease of the femoral and popliteal arteries using autogenous saphenous vein graft have been encouraging and gratifying. Immediate relief of rest pain and claudication was impressive, and continued function of the graft has often obviated the need for amputations. ■

1374 Nuuanu Ave., 96817

REFERENCES

1. Edwards, W. S.: Composite reconstruction of small leg arteries after endarterectomy, Surgery 51:58-61 (Jan.) 1962.
2. Edwards, W. S.: Late occlusion of femoral and popliteal fabric arterial grafts. Surg. Gynec. Obstet. 110:714 (June) 1960.
3. Wosolowski, S. A., Fries, C. C., Karlson, F. E., Debakey, M. E., and Sawler, P. N.: Porosity: primary determinant of ultimate fate of synthetic vascular grafts, Surgery 50:91 (July) 1961.
4. Cannon, J. A., Barker, W. F., and Kawakami, I. G.: Femoral popliteal endarterectomy a treatment of obliterative arteriosclerotic disease, Surgery 43:76 (Jan.) 1958.
5. Barker, W. F., Hart, J.: Arterial reconstruction by endarterectomy four years follow-up study, Amer. J. Surg. 100:165 (Aug.) 1960.
6. Spencer, F. C., Rienhoff, W. F.: Reconstructive surgery for occlusive disease of femoral and popliteal artery, Surgery 54:709-712 (Nov.) 1963.
7. Linton, R. R., Darling, R. C.: Autogenous saphenous vein bypass in femoropopliteal obliterative arterial disease, Surgery 51:62-73 (Jan.) 1962.
8. Morris, G. C., Jr., Wheeler, C. G., Crawford, S. S., Cooley, D. A., Debakey, M. E.: Restorative vascular surgery in the presence of impending and overt gangrene of extremities, Surgery 51:50-57 (Jan.) 1962.
9. Hall, K. V.: The great saphenous vein used in situ as an arterial shunt after extirpation of the vein valves, Surgery 51:492 (Apr.) 1962.
10. Connolly, J. E., Harris, E. J., Mills, W., Jr.: Autogenous in situ saphenous vein for bypass of femoral popliteal obliterative disease, Surgery 55:144-153 (Jan.) 1962.





# *The President's Page*

The medical profession and the Federal government for about a decade have been surveying the health needs and the type and quality of medical care being provided the people of the U.S. In 1962, the National Commission on Community Health Services was established by the National Health Council and the American Public Health Association. The Commission published findings under the title, "Health is a Community Affair." This Commission also founded six task forces, which contributed to the total effort of the National Commission on Community Health Services. One of these was the Task Force on Comprehensive Personal Health Service, and its report was entitled "Comprehensive Health Care, A Challenge to American Communities." It contains an extensive section on personal health services.

The Millis report talks about the "primary" physician. The National Commission on Community Health Services talks about the "personal" physician, and the Ad Hoc Committee of AMA for Family Practice talks about the "family" physician, new appellations for the general practitioner. The Ad Hoc Committee lengthily defines the scope, extent, and quality of services which ideally should be provided by the family physician during total comprehensive care.

Medical science and its related fields have been changing rapidly. Because of the dearth of new information and techniques through research, even the specialty fields have become fragmented. There is a tendency to overlook the patient as a whole being.

Whether medical care is provided by a family physician, an internist, a pediatrician, or any other specialist, it should not only be disease oriented, but should be oriented to total comprehensive care of the individual as a social, living being, one who is a part of the entire community—an integral part of the whole.

I cannot agree in toto with the various reports concerning family physicians, for basically I believe, whether one is a specialist or not, he should be a physician first and at all times. Whether one is a specialist or not, no one ean be wholly proficient in the ever increasing scientific knowledge of the times. Therefore, it behooves us physicians to know our limitations and to take what I might term the "corporate" approach. By that, I mean that we should learn to act like a president of a corporation in obtaining the best possible individuals to help us give the best comprehensive medical care to our patients. The doctor, like the president of a corporation, must be in total charge of the patient. While he directs, he will delegate responsibilities to various individual physicians, but he should require that each report back to the president. The president then can advise the patient in a meaningful, understandable manner concerning his problems. Only in this manner can more comprehensive personal health services be provided.

To stay abreast of the ever increasing new scientific and social changes, each of us should endeavor to take advantage of continued education. P.L. 89-239 provides us with this opportunity. The University and our community hospitals should take the initiative and leadership in providing centers of excellence where physicians can take part in research and in continued medical education.

To insure the success of this concept of comprehensive personal health care, a bold new concept of comprehensive medical care which is predictable in cost should be initiated by the physicians—for our national and local Blue Shield programs have failed miserably. A doctor-sponsored program will surely eliminate third-party control of medicine.

To achieve success in any endeavor, we must have convictions. And we may have to sacrifice security.

Theodore Tomita, M.D.

HAWAII MEDICAL JOURNAL

# Editorials

## Home Care Program

Home Care extends to the home many services that up to now have been available only in hospitals. Through coordinated planning, evaluation, and follow-up procedures by the Home Care team, patients receive physician-directed nursing care, medical social work, physical therapy, occupational therapy, drugs, laboratory services, and sick room equipment in the home. Home Care is seen as a therapeutic, inexpensive alternative to long-term hospitalization or institutional stays.

In the beginning, only residents in urban Honolulu were served. The administration of St. Francis Hospital, parent agency of the Honolulu Home Care Service, agreed to extend services to the entire Island of Oahu as of July 1, 1966, at the request of the State Department of Health. In August, there were four referrals from these areas and five the following month. This has gradually increased to twelve.

Federal–State funds were made available to expand and improve services of the Honolulu Home Care Program just prior to July 1, 1966, and March, 1967. This allowed for the purchase of office equipment, the inventory of sick room supplies and specialized equipment was increased, two station wagons and a car were added to the car pool. Without this equipment, it would have been impossible to provide service to all rural areas.

As of April 1, 1966, there were 48 patients on the program. One year later there were 78. This increase could be attributed to the diversification of services provided at this time: three full-time public health nurses, one full-time physical therapist, one part-time occupational therapist, and two part-time medical social workers.

A fifth service was added in late September—that of Home Health Aides. The aides are assigned to patients needing personal care of a type which can be safely and adequately provided by them. Their services are given under a physician's orders and are supervised by a professional nurse or another appropriate team member. This is a most welcome addition to the staff and provides a most needed service.

A full-time Director was employed in February and recruitment is now under way to employ a Public Health Coordinator to service the hospitals not yet visited.

During the six-month period of April, 1966, through September, 1966, a total of 2,057 visits were made. From October, 1966, through March, 1967, 2,971 visits were made, an increase of 914 visits.

## Dietitians and the Medical Team

Most good dietitians are not utilized to their fullest potential in the hospital milieu, says J. Mayer, writing in *Postgraduate Medicine* of last August. They are planning menus and directing kitchen activities when they might better be accompanying the internists and even the surgeons on ward rounds, contributing their special expertise in nutrition to the taking of the history, and the prescribing of the diet.

Not only is a doctor's time too valuable for long, drawn-out discussions of what patients have been eating and how they should modify this in future; a doctor is not so well informed on the subject of foods as a dietitian is and cannot therefore get such information, or give it, as easily as she can.

A start has been made in some medical groups, and in the offices of a few perceptive and efficiency-minded internists and generalists, by adding a dietitian to the staff to examine nutritional histories in detail, and to explain the implementation of special therapeutic diets, not only conserving the busy physicians' time, but doing the job better than they would do it.

If the principle is aecepted, and there seems to be no reason why it shouldn't be, then the training of dietitians should probably be oriented somewhat more along the lines of therapeutic dietetics. The dietitian can become, with a little encouragement, an important and effective member of the medical team.

# Hawaii Academy of General Practice

The Queen's Hospital Administrator, Will Henderson, presented us with the long view of the future of the practice of medicine at the May meeting of the Honolulu County Medical Society. He was a member of a panel of people in government, or dealing with the government, discussing medical care.

Mr. Henderson stressed the common denominator in all these recent numbered public laws—"the will of the people"—to which, of course, the Congress is sensitive. It is the "will of the people" that medical care be designated a right for all and not just a privilege for a few; it is the "will of the people" that hospitals provide the emergency medical care on an outpatient basis that will inevitably produce hospital–doctor complexes. To the people, an emergency may be a sudden indisposition, not necessarily only a cut finger, or it may be an aggravation of a previously tolerated subclinical illness. To the people, in such an "emergency," when doctors are not in their offices, or when the patient does not yet have a doctor known to him, or, knowing the doctor, the patient also knows he cannot get in to see him, the hospital emerges as the purveyor of relief.

An objective appraisal of the medical public laws, the "Medilaws," if you will, should reveal to us all that the intent of the Congress, as a reflection of the "will of the people," is to provide a network system of top-notch team medical care available throughout the USA. It goes without saying, that the high cost of modern medical and surgical equipment needed to implement such a program requires a hospital sort of complex, so that maximum usage thereof may be enjoyed at reasonable cost to the individual. It only follows that the differentiation between the patient's being considered in- or out-, will be whether he occupies a bed in the hospital, in the overnight emergency ward, in an adjacent extended care facility, or in his own home, or back and forth between these beds as his affliction warrants. We, as physicians, may be wise to consider carefully this concept of the future.

This will mean not only the relegation into the discard of the solo practitioner of medicine or surgery, especially the one in his home-office combination on some quiet, suburban corner, but it will also mean that our working places will be hospitals, or "hospital-like."

Consider the large 50-man clinic here in town: if it built itself its own hospital right there, it would become The Compleat Unit of Medical Care, and its own patients would undoubtedly be very happy about it.

Consider all the physicians (minus the above fifty, of course!) who now hospitalize their patients primarily at Queen's; did they but have their offices on the hospital grounds, in a high-rise of necessity, theirs also would be a compleat unit. True, these units would then become closed staff affairs, but if there were also similar doctor-hospital units at Kuakini, one in Waikiki, one at Castle on the Windward side, one at Wahiawa, to name but a few possible centers, people would have a "free choice of clinics" instead of the proverbial free choice of physician. The choice would become a simpler one, more certain of assured excellence, more all-inclusive—if somewhat less personalized.

In the ultimate, the patient would come under team care, albeit he could perhaps have a personal manager to guide him through the complex. *Here* is where the general practitioner of the future could best assume a specialized role as he follows his protege from otolaryngology through proctoscopy, through X-ray, laboratory, and assist at surgery, keeping the narrowed intentions of the other specialists within reasonable bounds of *his* patient's general welfare!

The implications herein are worthy of serious thought.

J. I. Frederick Reppun, M.D.

HAWAII MEDICAL JOURNAL

# This Is What's New!

• **Indomethacin** (Indocin) was given to 30 patients with classical **rheumatoid arthritis** in doses up to 125 mg a day. Indomethacin had **no anti-inflammatory effect** in any of the patients studied. The indomethacin accelerated the erythrocyte sedimentation rate, and did appear to have a specific **antifatigue effect.** (*Brit. Med. J.* [Jan. 14] 1967.)

• **Maple syrup urine** disease, that unusual inborn disease of metabolism that was described a few years ago and characterized by urine that smells like maple syrup, appears to be effectively treated by a special diet. If the intake of three **branched-chain amino acids,** leucine, isoleucine, and valine, is controlled, the neurological manifestations improve and **normal growth** is achieved. (*Amer. J. Dis. Child.* [Jan.] 1967.)

• The University of Edinburgh Department of General Practice recommends a sharply focused history with a minimal physical examination for certain groups of patients consulting general practitioners or hospital outpatient departments for the first time. (*Brit. Med. J.* [Dec. 24] 1966.)

• Added to the growing list of **spare parts** are the **ear ossicles.** Because of good results with use of autograft and reconstruction of the anatomical relation of the incus, a homograft incus was tried in cases where no ossicles remained. The cadaver incus was implanted in the appropriate position. Satisfactory hearing was obtained in 80 per cent of cases, without loss of the ossicle or infection. (*Arch. Otolaryngol.* [Apr.] 1967.)

• The anti-inflammatory drug, **oxyphenbutazone,** has been used in the treatment of **chronic bronchitis** with objective and subjective improvement. No significant side effects to the drug were observed. Ninety per cent of the patients had decrease in the sedimentation rate and white count. (*München. Med. Wschr.* [Mar. 17] 1967.)

• **Oxygen under high pressure** increases the survival in mice inoculated with **tetanus** spores. Whether the high pressure oxygen is administered immediately after inoculation of the mice with tetanus spores or delayed as long as 24 hours, there is an increased number of survivors among the mice receiving the high pressure oxygen. The percentage of survivors, however, decreases with delay in administration of the oxygen. (*Aerospace Med.* [Feb.] 1967.)

• **Coronary arteriography** is indicated, according to a researcher in Palo Alto, in patients with **angina pectoris** being evaluated for coronary endarterectomy, in those with **valvular heart disease** being considered for cardiac surgery and those under the age of 50 with **chest pain of undefined origin.** In 55 patients studied by this technique, only the electrocardiogram exercise tolerance test correlated closely with coronary disease demonstrated by arteriography. Two major coronary arteries were occluded in all patients with angina and positive exercise EKG tests. (*Amer. J. Med.* [Feb.] 1967.)

• Patients **admitted to the hospital** without infection have a fairly good chance of acquiring one after admission. Some 6 per cent of patients admitted to an Eastern hospital eventually **acquired infections. Two-thirds** of such infections were due to **gram-negative bacilli,** which are replacing the Staphylococcus aureus as the more serious hospital-acquired infection. (*Ann. Int. Med.* [Mar.] 1967.)

• The argument "Don't blame or congratulate me, congratulate or blame my environment" is shifting, with the credit going to the chromosomes. Careful study of nine men having **XYY sex chromosomes** and confined to a maximum security hospital revealed a very **clean family history** as regards crime or mental illness. The **behavior disorder** in the patients studied was blamed on the extra Y chromosome. (*British Med. Jour.* [Mar. 4] 1967.)

• The **antitumor antibiotic,** Daunomycin, which reacts with DNA, causes **remissions of leukemia** in 60 per cent of children treated and briefer remissions in some patients with **neuroblastoma, reticulum cell sarcoma** and **rhabdomyosarcoma.** (*Cancer* [Mar.] 1967.)

• The potent **diuretic,** Furosemide, in the dose of 40 to 160 mg daily over a year, produced **no major side effects** in 16 patients so treated. In addition to the sodium and potassium and water diuresis, there was also a reduction in **blood pressure, elevation of fasting blood glucose, increased uric acid** concentration, and **lowering of plasma potassium.** (*Gen. Clin. Pharmacol.* [Jan.-Feb.] 1967.) ■

F. I. GILBERT, JR., M.D.

HAWAII MEDICAL JOURNAL

# *In Memoriam Doctors of Hawaii*

This is the sixty-seventh installment of In Memorian—Doctors of Hawaii.

## Peter Alexander Mjedloff

Peter Alexander Mjedloff was born in Moscow, Russia, on March 6, 1888. His father, Alexander Mjedloff, was an administrator at the Moscow School of Arts and Crafts, and his mother, Eugenia K. (Vlasevskaya), a former student of the school, was an artist.



DR. MJEDLOFF

After graduating from high school, Dr. Mjedloff entered Moscow University to study law, at his father's wish. He received his law degree in 1910, but in fulfillment of his own wishes remained at the University to study medicine. He married Maria Streltzova, a teacher in the Moscow elementary schools, on January 8, 1914.

Dr. Mjedloff's medical studies were interrupted by World War I. In 1915 he was called for military duty and was sent to the Russian Naval Hospital in Vladivostok, Siberia, where thousands of wounded soldiers were housed. In 1927, when the Bolshevik revolution began, Dr. Mjedloff was allowed to go inland to the University of Tomsk in western Siberia to take final examinations for his medical degree. Upon his return, and upon request of Sir Charles Elliot, British High Commissioner to Siberia, he became medical officer to the Middlesex Regiment. On completing this assignment, which ended with the evacuation of the British regiment, Dr. Mjedloff joined the American Red Cross staff in Vladivostok.

He was placed in charge of the large ARC hospital there, which was chiefly engaged in the relief of thousands of Russian refugees who were brought in trains from the interior as an aftermath of both war and revolution. Dr. Mjedloff also served as physician to the Petrograd Children's Colony at the Russian ARC hospital under Riley H. Allen of Honolulu, who was American Red Cross Siberian Commissioner at that time, and later, until his death, Editor of the *Honolulu Star-Bulletin.*

Following the removal of the American Red Cross from Siberia in 1920, and with the assistance of both Mr. Allen and Dr. W. D. Baldwin of Maui, Dr. Mjedloff was able to come with his family to Maui. For four months he was associated with Dr. George T. Webb at Pioneer Hospital in Lahaina. From there he went to Kula Sanitarium where he worked with Dr. Charles Durney for three and a half years. His special interest was bacteriological research, and, at the special request of Dr. Webb, he helped combat a serious outbreak of meningitis in Lahaina.

In 1924 he accepted a position as assistant in medicine and surgery to Dr. Gordon Lightner at Puunene Hospital, where he remained until his death at the age of 41, on November 27, 1929. He had been attending a medical convention in New York, and died from an embolism following surgery there.

Dr. Mjedloff spoke French, Russian, German, and English fluently, and was also able to converse with his Japanese and Filipino patients in their own languages. He was a first lieutenant in the Medical Corps, Hawaii National Guard, a government physician, and local registrar for the Puunene-Kihei and Kula districts of Maui, and had been appointed bacteriologist for the Island of Maui by the Territorial Board of Health shortly before his death. He was a member of the American Medical Association and the Maui County Medical Society.

His son, Alexander, resides in Glendora, California. He is director of contracts for a precision-tool company in Los Angeles and the father of three children. Dr. Mjedloff's elder daughter, Olga, lives in Honolulu and is married to Dr. William A. Myers, a pediatrician at the Straub Clinic. Another daughter, Eugenia, in Walnut Creek, California, is the mother of a son and a daughter. Mrs. Mjedloff now lives in Honolulu, after having resided for many years in Berkeley, California.

Written by MRS. WILLIAM MYERS

HAWAII MEDICAL JOURNAL

# Book Reviews

## Atlas of Hernia Repair

*By Carl H. Calman, M.D., F.A.C.S., 159 pp., $16.75, The C. V. Mosby Company, 1966.*

THIS IS A DESCRIPTIVE, readable, and well-illustrated book on hernia, intended for the physician early in his surgical training. The common external and the uncommon internal hernias are presented in a straightforward fashion.

It is perhaps unfortunate that the historical background is passed over lightly and the methods of repair presented "are those that are found most applicable in daily use." The less common repairs are intentionally omitted. The advantage of brevity and conciseness does not outweigh the fact that the material presented, and more, can be found in many other surgical textbooks.

FRANCIS T. ODA, M.D.

## A Primer of Electrocardiography, 5th Ed.

*By George E. Burch, M.D., F.A.C.P., F.A.C.C., and Travis Winsor, M.D., F.A.C.P., 304 pp., $6.50, Lea & Febiger, 1966.*

THIS TEXT of electrocardiography was first published in 1945 and there have subsequently been four more editions; the present text is the fifth edition. It is an attempt to write a relatively inclusive textbook of electrocardiography starting at basic electrophysiologic concepts, carrying them through to clinical electrocardiography, and finally pointing out the usages of the clinical electrocardiogram in the diagnosis and treatment of patients.

To my mind, the purpose is admirable but the means are somewhat lacking. It is apparent to me that this text has been modified very little since its first edition, because its concepts are outmoded according to recent trends in cardiology. The text attacks the vectorcardiogram as a clinical tool as early as the introduction, and then frequently throughout its contents uses vectorcardiographic concepts, and finally dedicates a section to its potential clinical use. It also has, to my mind, a poor explanation of the bundle branch blocks; certainly the concept that right bundle branch block always means heart disease, as is stated here, is generally not accepted now. Further, the criteria mentioned for Wolff-Parkinson-White syndrome are incorrect (a short PR interval is not necessary). Other examples of need for further modification are the incorrect values for the left axis deviation, the use of the obsolescent term "posterior infarct" when "inferior infarct" is meant, and other terminology, such as left ventricular "strain," which no longer meets favor among modern cardiologists.

Other criticisms of this book could be made about specific points but for lack of space; perhaps some of its good features should be rewarded with comment. Its appendix is probably valuable reference material for the electrocardiographer; further, the method of systematic interpretation of the electrocardiogram described herein is as good a one for the budding cardiographer to use as any I have seen.

In summary then, this is the fifth edition of a book which was modern in 1945 but needs considerable revision to approach modern concepts and standards.

EDWARD L. CHESNE, M.D.

## ★Inborn Errors of Metabolism, Part I: Clinical Aspects

*By David Yi-Yung Hsia, M.D., 396 pp., $11.00, Year Book Medical Publishers, 1966.*

## ★Inborn Errors of Metabolism, Part II: Laboratory Methods

*By David Yi-Yung Hsia, M.D., and Toluru Inouye, Ph.D., 244 pp., $7.00, Year Book Medical Publishers, 1966.*

FOR THE PRACTICING physician who desires a simple and understandable "primer" of inborn errors of metabolism, these two volumes will make most welcome companions on his desk. The major advances and discoveries in this field compel the practicing physician to acquaint himself with these diseases. Dr. Hsia presents the data in a simple and concise manner, and while the more sophisticated reader may desire other, more comprehensive, texts, this text is more than adequate for the clinician who desires to understand and diagnose these disorders.

The first volume deals with the clinical aspects of these disorders, with sufficient genetic and biochemical background to allow a physician to comprehend and diagnose them. The second volume is primarily written for clinical pathologists and laboratory personnel to aid in the detection of these disorders.

Rapid progress in this field has enabled the clinician to detect these disorders with increasing frequency. In Hawaii, diabetes mellitus and gout are among the most common entities seen, while disturbances such as porphyria, thalassemia minor, and glucose 6-phosphate dehydrogenase deficiency are becoming increasingly recognized. Thus, the availability of this concise and authoritative text on inborn errors of metabolism is most welcomed by most clinicians.

WINFRED Y. LEE, M.D.

## Diseases of the Heart, 3rd Ed.

*By Charles K. Friedberg, M.D., 1,787 pp., $26.00, W. B. Saunders Company, 1966.*

THE AUTHOR has updated much of the subject material in this new edition because of the abundant clinical and investigative studies published during the past few years. As a result this is a much larger textbook, with almost 700 new pages added.

Included in this edition is a section dealing with advances in the treatment of cardiac diseases. Also presented is a discussion of the newer diuretics and recent work on the action of digitalis. The surgical aspect was also considered.

The bibliography has been modified by the addition of the title of each individual reference.

This is an excellent textbook because of its varied and recent facts which the reader will find most rewarding.

CHARLES CHING, M.D.

## ★Psychotherapy and the Behavioral Sciences

*By Lewis R. Wolberg, M.D., 198 pp., $6.75, Grune & Stratton, 1966.*

ALL PSYCHIATRISTS and others interested in the mental health field should have this excellent book in their personal library to read and to use as a reference book. Although only 198 pages in length, it brings together and

*continued page 468*

★ means highly recommended.

HAWAII MEDICAL JOURNAL

# New Members



**Mary Kathryn Beard Redford, M.D.**
1481 South King Street, Room 322
Honolulu, Hawaii 96814

GENERAL PRACTICE
University of Missouri—1961-1963
University of Arkansas—1965
Internship—St. Francis Hospital—1965-1966



**Frank McDowell, M.D.**
254 Alexander Young Bldg.
Honolulu, Hawaii 96813

PLASTIC SURGERY
Washington University, St. Louis—1936
Internship—Barnes Hospital—1936-1937
Residency—Barnes Hospital—1937-1939



**Ann Barbara Ho Yee, M.D.**
1270 Queen Emma Street, Suite 306
Honolulu, Hawaii 96813

PEDIATRICS
Woman's Medical College of Pennsylvania—1961
Internship—Episcopal Hospital (Phila.)—1961-1962
Residency—Hospital of the Woman's Medical College of Pennsylvania—1963
Kauikeolani Children's Hospital—1964-1965

# County Society Reports

## Hawaii

Dr. Duke Cho Choy, Mr. Richard Kennedy, and Mr. John Cabral were guests at the March 23 meeting. The treasurer advised that only five members' dues were still outstanding. Dr. Bergin reported on the meeting of the Medical Payments Advisory Committee to the DSS and Dr. Miyamoto emphasized that the individual doctors should bill their usual charges, letting the DSS make the discounts. Members were invited to attend an oral cancer detection clinic to be held on June 6 in Hilo. A letter from Dr. George Schnack relative to psychiatric workshops was read. It was voted to advise him that the Society is interested. In answer to a request from Dr. Tomita, a discussion took place on fluoridation and it was unanimously voted to favor fluoridation.

After commenting on the work of the HMA's Medicine and Religion Committee, Dr. Choy spoke on "Hypnosis in Private Practice." The meeting concluded with a presentation by Mr. Kennedy on the important aspects of the up-coming public hearing on Workmen's Compensation fees. Drs. Miyamoto, Okumoto, and Mr. Cabral were appointed to coordinate efforts and prepare for a united presentation at the hearings.

## Honolulu

Approximately 165 members were present at the February 7 meeting. One new member, Alfred D. Morris, was introduced. The speaker for the evening was Dr. Harold G. Jacobson, Chief of Diagnostic Radiology at Montefiore Hospital in New York. He spoke on "Roentgen Aspects of Some Pituitary and Parapituitary Lesions." The Society was advised that Workmen's Compensation Bureau had adopted a medical fee schedule which reflects in general the Hawaii RVS and a conversion factor of 5.00, effective February 15, for Oahu only. Four new Foundation contracts were announced.

Dr. Chew Mung Lum reported on the HMSA negotiations. He asked for direction and advice from the membership. Several motions were made and a substitute motion was passed to postpone negotiations indefinitely unless HMSA accepts the minimum requirements as stated. Dr. Lum stated that he had been told at the January 10 meeting with HMSA that the Negotiating Committee had failed to allow the minority to express its feelings. He asked for an open discussion. His fairness was attested to by several members and the meeting adjourned at 9:35 p.m.

*continued page 468*

HAWAII MEDICAL JOURNAL / Hawaii Medical Association

## MINUTES OF THE COUNCIL MEETING

**April 21, 1967, at 6:00 p.m.**
**Oahu Country Club**

### PRESENT

Drs. Theodore T. Tomita, B. A. Richardson, O. D. Pinkerton, Herbert Y. H. Chinn, R. Varian Sloan, Joseph E. Andrews, Grover H. Batten, Bernard W. D. Fong, Andrew C. Ivy, Jr., Robert M. Miyamoto, and Samuel R. Wallis, plus Dr. George H. Mills, Dr. Samuel D. Allison, Dr. Richard T. Mamiya, Dr. Keith F. O. Kuhlman, and Messrs. Thomas Rice and T. Thorson.

### MINUTES

The minutes of the February 1, 1967, meeting were approved as printed in the JOURNAL.

### COMMUNICATIONS REQUIRING ACTION

*AMA Disability Program:* Reams of correspondence have been received on this subject as well as a number of telephone calls. The Council may wish to develop a resolution for submission to the House of Delegates and instructions for the AMA Delegate.

The Delegate reported that the Program started in 1962 with Continental Casualty as its carrier. Many complaints come in from members because of the adjudication of claims. The House of Delegates found the plan to be fiscally unsound and therefore referred this matter to the Board of Trustees. The Delegate pointed out that Mr. Finley, AMA Insurance Broker, has been fired. It was noted that there are 40,000 physicians across the nation who are participating in this program. It was also noted that there is a five-year contract with Continental Casualty; the contract ends this year. The Firemen's Fund in Los Angeles, through Mr. Finley, agreed to continue this program unchanged. The Delegate stated that there is an Advisory Committee studying this matter, Its Chairman is Dr. Appel. This Committee will make its recommendation to the AMA House of Delegates in June.

**ACTION:**

**It was moved and seconded that the AMA Delegate be given the responsibility to use his best judgment in the way he votes on this matter.**

**Dr. Moore suggested that HMA wait to see what the House of Delegates comes up with at their meeting in June. He felt that perhaps a decision could be made by the HMA after the June meeting and then presented at the AMA Clinical Convention.**

**This matter will be presented to the HMA House of Delegates.**

*Letter from Aetna:* A letter from Aetna to Mr. Breezer Bush, Industrial Relations Coordinator of Theo. H. Davies Company, Ltd., reads:

A question has frequently arisen regarding direct payment to plantation physicians for physicians' services under the Medicare Law. This mainly has to do with an outside consulting physician. An example of one situation currently in practice was referred to our Home Office Medical Claim Administration and their answer and suggestion follows. When a Medicare beneficiary is seen in consultation by an outside physician, and this physician then bills the plantation which pays the bill, could we make the check payable to the plantation. Two potential methods of handling the situation were presented to our Home Office. One, was the attachment of a note signed by the beneficiary, requesting payment to be made to the plantation. The other was that of joint payees, the check being made payable to the beneficiary and the plantation. The Home Office has advised that neither of these two methods can be used for Medicare. They have suggested the following procedure for your consideration, if you have a similar problem. The consulting physician should bill the applicable plantation physician for his services and then have the plantation physican bill the beneficiary for the services for both physicians. We can then make payment to the plantation physician on assignment from the beneficiary. It will then be up to the plantation physician to pay the consultant the benefits he received (the plantation physician) for the consultant's fees . . .

The above letter was answered by the President of HMA as follows:

With reference to Aetna's letter to Mr. Bush, we would like to call your attention to a principle of medical ethics and suggest that the proposal as outlined be withdrawn. All our members are bound by the AMA's Code of Medical Ethics and we quote below sections from the Judicial Council's rulings which apply to your proposal.

Combined or Joint Bills: The Judicial Council has stated repeatedly (in its June 1954 Special Report and its December 1952 Annual Report, to cite two occasions) that, when two or more physicians actually and in person render service to one patient, they should render separate bills. The Special Report of June, 1954 indicates two exceptions to this general rule, namely, when a patient requests a single bill or when an insurance company demands one. The Council has insisted, however, that these instances are to be recognized as exceptional cases and not routine. (Judicial Council, 1957).

Physicians should render separate bills: In many cases insurance companies insist on a joint or combined bill, but the bill is being paid in most instances by two checks. This is not considered unethical, and all insurance plans which do not pay the individual physician in this manner should be urged to do so. The Judicial Council is still of the opinion that, when two or more physicians actually and in person render service to one patient, they should render separate bills. There are cases, however, in which the patient may make a specific request of one of the physicians attending him that one bill be rendered for the entire services. Should this occur, it is considered to be ethical if the physician from whom the bill is requested renders an itemized bill setting forth the services rendered by each physician and the fees charged. The amount of the fees charged should be paid directly to the individual physicians who rendered the services in question. (House of Delegates, 1954). I am certain that it was not the intention of Aetna to propose a manner of billing for physicians which is contrary to their code of ethics and sincerely hope that the proposed manner of billings has not been put into effect.

Aetna replied as follows:

On many occasions we see charges on physicians' billings which are for services of another physician. Because we see the practice daily, we should not have added to it, by suggesting the Plantation physician part, I am sorry. Our company does not wish to contribute to the existing problem, so by carbon copy of this letter, I am requesting that Mr. Bush disregard our suggestion. We will endeavor to assist by referring offenders to the proper medical society committee if you wish. In fact we must be consistent in what we do so would appreciate your support in declining charges of physicians when they do not perform the service.

The Council was asked to give Aetna assistance whereby they can refer names of physicians who are billing in such a manner.

**ACTION:**

**It was voted that a letter be sent to Aetna Life Insurance Company suggesting that physicians who are not properly informed be referred to their component society.**

**It was also voted that the County Medical Societies be informed that Aetna will be referring these names to them for some course of action.**

*Request from the Bureau of Medical Economics:* The Bureau of Medical Economics sponsors a Seminar for Medical Assistants and Secretaries every year. Tro-

*continued page 462*

HAWAII MEDICAL JOURNAL

# Notes and News

## Professional Moves

Perhaps tax time has a stunning effect on the medical community, for it was unsually static in March and April. In March, pediatrician **Roy Kuboyama** relocated to the Kalihi Medical Center and psychiatrist **Lothar Varady** opened his office at the Kailua Professional Center. In April, two generalists, **H. O. Nordstrom** and **Herman P. Kramer,** relocated to the Kailua Professional Center.

## Hors de Combat

We gleaned this item in *Pacific Business News* December 19 issue from a weekly listing of cases filed in Circuit Court. "C-20664—**Clarence M. Burgess** and Grace T. Burgess vs. **Frederick M. K. Lam** and Marie L. Lam. Suit to abate nuisance allegedly constituted by barking, howling, and yelping of dogs maintained by defendants." Tsk, tsk, tsk! . . . We recommend tranquilizers for all parties concerned, especially the dogs.

A Honolulu psychiatrist, **John Nasse,** and three others were reportedly forced off the Honolulu yacht "Nirvana" by a gun-toting skipper at Fanning Island, 1,100 miles south of Oahu. The Coast Guard is investigating the incident. The party insists that it left the ship voluntarily, though admitting there had been an argument with the skipper.

Protagonist **Willis Butler** and cohorts were again found guilty of disorderly conduct in a Circuit Court attempt at acquittal for the October 17 incident at the East-West Center where they held up on bamboo poles effigies of LBJ and the Pentagon. The fine at the district court level was $500. Now the ante is upped to a possible penalty of one year in jail, or $1,000 fine, or both. [Dr. Butler is not a member of the HMA. Ed.]

**Bob Wong** and his neighbors in Diamond Head Circle were up in arms because there is no grass in the yard of the new high-rise apartment house nearby. The backyard of the six-story building is a solid sheet of black asphalt. When Fighter Bob gets his dander up, we can always expect action. "I intend to see the right thing is done," he said.

We were not at all surprised to see that physician, surgeon, and sports official **Richard Yon** had the second longest list of achievements (he had two columns while Henry Kaiser filled 3½ columns) in the eighth edition of *Men and Women of Hawaii*. Quite notable was the fact that he advanced from private to sergeant in the Hawaii National Guard from 1932 to 1939.

The Kona Medical Association Building was robbed of $293.76 worth of drugs in March. This amounted to exactly 14,625 tablets and capsules. We were surprised to see such an accurate inventory being kept.

## Visiting Physicians

Both tourism and the local medical circles benefited from the continued inclement weather on the mainland. Some particularly excellent medical educators left their snow-bound regions to bask in our warmer, but rain-soaked islands.

From Chicago came cardiologist **Oglesby Paul,** Professor of Medicine at the Passavant Memorial Hospital. The tall, lean, serious lecturer was the Visiting Professor of Medicine at Queen's for two weeks in February and made overnight cardiologists of us.

From even colder Canada came the Visiting Professor of Pediatrics, **W. A. Cochrane,** for the months of February and March at Children's Hospital. This tall, athletic, bushy-browed redhead, who looks more like a Canadian lumberjack than a distinguished clinician and professor of pediatrics, gave learned and well-attended lectures on metabolism, nutrition, and other facets of pediatrics.

In early March came another renowned cardiologist, bespectacled, and grey but fully-haired **Franklin Johnston** from Michigan. Franklin prefaced his soft-spoken, unembellished lectures on arrhythmias and cardiography with the admission that Ann Arbor had its worst winter since grandma's days and that he was happy to be here. We remember the story from Michigan days how this former engineering instructor at the U of M was stricken with diabetes and became one of the first patients to be tried on insulin therapy. This prompted the fortunate switch from engineer to physician.

From the University of Minnesota Medical School came stocky, ruddy-complected, frontal-alopecic **Wesley Spink** as Visiting Professor of Medicine at Queen's for two weeks in March. His lectures covered staph, salmonella, pneumonia, and antibiotic and steroid therapy, and were warm, practical and entertaining. We particularly enjoyed seeing him laughing at his own jokes, but frequently had to join him belatedly when he started laughing before finishing a joke.

Another escaper from the winter freeze was **Jerome Conn** from Michigan, who was the same captivating lecturer we remembered as med students. He spoke to capacity crowds at Mabel Smyth, where he propounded the concept that aldosterone-secreting tumors may be the basis for much of the so-called essential hypertension.

### ROBERT W. DAVIS, M.D.
### 1930-1966

Dr. Davis was born February 14, 1930. He attended McGill University, receiving his Doctor of Medicine Degree in 1959. He interned at The Queen's Hospital from 1959 to 1960, and had a surgical residency there from 1960 to 1961.

He went to Kwajalein from 1961 to 1962 for the Transport Company of Texas, then returned to the position of resident physician at the Hawaii State Hospital from 1963 to 1964. He then went to the Kahuku Medical Clinic for a year, following which he went to Johnston Island for Holmes and Narver.

On November 1, 1965, he joined Leeward Clinic at Aiea, living in Honolulu with his wife Theeocly and two small sons, Michael and Peter.

During the Korean War he was a medical paratrooper and received a Presidential Citation and the Bronze Star.

After a year of ill health, Dr. Davis died of accidental suffocation on November 22, 1966.

P. H. Liljestrand, M.D.

Here's to continued cold winters in the midwest and sunny, rainless weather here!

The Visiting Professor of Medicine at St. Francis Hospital was athletic, personable, vivacious lecturer **Henry Brainerd** from the University of California, whom we discovered to be equally versatile on the tennis courts and on the lecture podium.

When 70 members of the American Academy of Pediatrics met at Children's Hospital for a one-day postconvention meeting following the Academy's spring meeting in San Francisco, local pediatricians **L. T. Chun, George Ewing, William Moore,** and **Calvin Sia** were kept hopping. **Frank Tabrah** from Kohala, Hawaii, spoke on "Polynesian Pharmacology."

Kuakini pathologist **Grant Stemmermann** moderated an ETV panel discussion on "Cancer in Migrant Groups" with **William Haenszel,** Ph.D., of the National Cancer Institute; **Calum Muir,** of the World Health Organization; and **Walter Quisenberry,** Hawaii State Department of Health chief. The week-long seminar on cancer in the migrants held at Leahi Hospital also included five cancer experts from Japan. Participating were **Susumu Majima,** of the Tohoku University of Medicine; epidemiologist **Minoru Kurihara,** also of Tohoku University; pathologists **K. Akazaki,** of the Aichi Cancer Center in Nagoya, and **Nobuaki Susano,** of the Tohoku University; and **Tamaki Imai,** of the Cancer Research Institute in Fukuoka.

## Sportsmen

*Tennis:* It was early Sunday morning at the Ala Moana Courts prior to church attendance. The game was going unusually bad and every point counted for tennis partners, **Sau Ki Wong** and **Larry Wong.** An errant ball barely trickled into their court from an adjacent game in progress. Sau Ki took a hefty swing at a swiftly served ball which sizzled through as if the racket gut had sudden dissolved. We sympathetically inquired if the other ball had disturbed him. Came the emphatic, unhesitant reply with unabashed candor, "Very much!"

Tennis, like other contact sports (ever get beaned by a tennis ball hit swiftly and aimed deliberately?) is a good way to get rid of one's aggressions. The "Sunrise Swingers" who play at the crack of dawn every Sunday morning effectively ventilate their pent-up hostilities of the week, it seems. The recent round robin series was won by two Dr. Jekylls, **Cal Sia** and **Charley Ching,** who turn into Mr. Hydes on the courts.

*Golf:* We finally signed up for the 11th Annual DDD Golf Tournament held Thursday, April 6, when we learned that the Calloway system was out and that handicaps were more "legit." With 108 other aspirants, we struggled over a windswept, former canefield with lush but tricky 3-putt greens, known as the Mililani Golf Course. The Waipio red dust stung our eyes and stuffed our nostrils, but somehow all participants managed to finish. The postmortem at the Kanraku Tea House revealed that Lady Luck, rather than talent, ruled the day, for a so-called golfer named **H. Yokoyama** won over-all low net with 79-11-68. **Francis Soon** was 2d, **Toots Fujii** 3rd, and **Ted Tomita** 4th. Things seem a little muddled, for **Mike Okihiro** also placed 4th and **Coolidge Wakai** 5th. (Whoever picked up Mike's 4th place prize, a rain jacket, please deliver to Mike.)

The continued inclement weather in March and April kept wiser golfers indoors, but we notice that the Waialae players were diehards. In March, **Toots Fujii** won A flight honors and **Richard Chun** B flight. **Blue Nishigaya** and **Kiku Kuramoto,** with their partners, were two up in F flight. In April, **Bill Hartwell** tied in B flight and **Al Ho** tied in individual Stableford.

We notice that few announcements emanate from the Oahu Country Club. **Marquis Stevens** was the lone physician tied with two others for A flight honors. This paucity of news makes us wonder if their members are not "juicing" their handicaps for the forthcoming HMA Golf Tournament. We predict that the HMA tournament in May will be won by an OCC member.

*Horsemen:* We were not the least surprised that indestructible **Clarence Fronk,** big game hunter and horseman extraordinaire, escaped with minor bruises when the horse he was riding reared up and toppled over on him. . . . Poor horse! But we are mystified by the apparent lack of team loyalty among polo players, for our **Masato Hasegawa** is continually changing teams week after week. He rode one week for Oahu against the Waikikians and next week for Hawaii against Oahu. In the ensuing weeks, he has ridden for the Tigers, the Mokuleia team, and the Waikikians. Confusing, wot?

*Water Sports:* In the Spring Regatta of the Waikiki Yacht Club, **Els Harris** was 2d on Saturday and 1st on Sunday in the PC Class while **Les Vaseoncellos** was DNF in 210 Class. **Tom Frissell** and his 13-year-old son Lang (Possum) went on an overnight trip to the Banks on the "Islander." Lang caught a 152-pound marlin and poor Tom caught none. Tough on the father image, eh? We read with interest Queen's intern and avid surfer **Ted Hard's** statistics on drownings around Oahu gleaned from the Medical Examiner's files. In 1966, there were 29 drownings with only three surfing deaths. Since 1961, there have been 173 drownings with only 13 surfing deaths. Ted concludes from this that surfing is a relatively safe water sport! We note also that placid Hanauma Bay has claimed the most drowning victims, followed by Makapuu, Pupukea, and Waikiki's Queen's Surf. Athletic **Bob Peyton, II,** is chairman of the Red Cross Safety Services, which has 49 schools enrolled in an eight-week "Learn to Swim" program.

*Bowlers:* Avid bowler **Diek Lam** and team were in second place in the 17th annual Oahu Bowling Association Championships in February.

## Doctors in Print

We congratulate the following for their contributions to medical knowledge: **William John Holmes,** "Preventable Eye Diseases and Blindness," Amer. Jour. Ophth. (Nov.) 1966; **G. N. Stemmerman,** "Cancer of the Colon and Rectum Discovered at Autopsy in Hawaiian Japanese," Cancer (Nov.) 1966; **David R. Bassett, Gerald Rosenblatt, Robert C. Muellering,** and **Alfred S. Hartwell,** "Cardiovascular Disease, Diabetes Mellitus and Anthropometric Evaluation of Polynesian Males on the Island of Niihau—1963," Circulation (Dec.) 1966; **Sorrell H. Waxman,** *et al.,* "Endometrial and Fetal Cytogenetics. Amer. Obst. Gynec. (Mar. 15) 1967.

The following extracts from John Holmes' interesting paper typifies the problems encountered in India: "Mobile Ophthalmic Units are effective means of attacking this problem. Two surgeons, assisted by nurses and medical students, can successfully operate on approximately one hundred patients in a single day. . . . There is religious bias toward corneal grafting. The eye of a person of a lower social status or of a different caste is unacceptable. In other areas, there is a vehement opposition to mutilation of the dead, this amounting to sacrilege. . . . In areas where illiteracy is still widespread, eyeglasses are a luxury, and indeed a status symbol rather than a necessity."

## Members Speak Up

The fluoridation issue was again debated by the same cast of anti's and pro's. **Harry Arnold,** noting the 100 or more elderly persons wearing dentures and "NO" signs parading outside the House conference room, said, "It is not right to leave this decision up to people who are not sufficiently well informed to have an educated view about it. . . . I see the crowds outside and I know how well they are informed. It is sad." **Lyle Phillips,** who opposes fluoridation, in a surprise turn about, supported a bill offering free fluoride pills for children. He said, "The

anti-fluoridationists agree generally that there is some benefit in fluorides in small doses." How odd, this reversal. Perhaps there is a glimmer of scientific sanity left in our physician anti's. Lyle's comment is in contradiction to that of fellow anti-fluoridationist, **F. J. Pinkerton,** who said, "Fluoridation will some day be recognized as one of the most stupid and dangerous so-called public health measures known to modern man." He maintains that fluorides contribute to cancer, heart, and kidney disease, and premature aging.

Psychiatrist **James Eriekson** has the perfect solution to the bus strike. In a Letter to the Editor entitled "Doing Without" James wrote, "Perhaps by deprivation we can prove that we don't need them. I think that this would be a beautiful justice to Mr. Weinberg and Mr. Rutledge should there be no passengers when the buses finally, if ever, get back on the road." Interesting.

Physician speakers covered a multitude of subjects: **Patrick Coekett** on Kauai spoke to a Kapaa High class on dating, sex, and marriage. Kailua pediatrician **Robert Dimler** was at Maunawili School to discuss the role of endocrine glands in controlling growth. **Paul McCallin** spoke to the U of H Dames' Club on natural childbirth and methods of birth control. Kailua physician **Harold Lawson** directed a five-day group therapy session, for smokers who want to break the habit, at the Hawaiian Mission auditorium. **Howard Liljestrand** showed and narrated a film, "Seeing India with the Maharajah" at the annual Valentine party of the Central Union Church. We were intrigued by the following announcement by the Honolulu County Medical Society Woman's Auxiliary: "Feeling saggy, baggy, draggy, and flat?? Join us to hear **Dr. Eldon Dykes** speak on plastic surgery on April 12." The **Tom Fujiwaras** spoke on lady slipper orchids at the Windward Orchid Society meeting in Kaneohe. **Ted Tseu** spoke on "Woman's Diseases" to the LPN association meeting at Kapiolani Hospital while **Clifford Straehley** spoke on "Smoking and the Teenager" at their earlier meeting at Kaiser Hospital. Maui pediatrician **Marion Hanlon** discussed the relationship of physical and emotional illnesses at the Kahului School PTA, and on Hawaii. **William Bergin** spoke to the juniors and seniors at St. Joseph's School on sex.

Since his well-timed appearance on the ETV panel on LSD in January, **Bill Stevens** has been in constant demand. More recently, he was one of five panelists at Punahou School discussing the medical, moral, and legal aspects of psychedelic drugs. Bill brought out that many of today's adults employ a variety of "socially acceptable" drugs during the normal course of living—a fact which tends to mollify the teenager's attitude toward drugs. He pointed out that most of us are addicted to nicotine and caffeine. "We take sleeping pills to get through the night, tranquilizers to get through the day, and diet pills to get through life. They all have their uses, and are more or less socially acceptable. But when it comes to the socially unacceptable controversial drugs like LSD or marijuana, a sort of Pandora's box has opened up for the teenagers. The point is, this group of drugs is highly versatile and does deserve study. But these drugs must be left alone until scientists have more time to determine their uses, controls, and effects."

When House Bill 76 (which legalizes abortions in certain specific cases) was being debated, our house was again divided as in the fluoridation issue. It was **George Goto, Ted Tomita, Satorn Nishijima,** and **Arno Mundt** vs. **W. N. Bergin, Keith Kuhlman,** and **Fred Dodge** (or non-Catholics vs. Catholics). Arno argued that the legislation would provide a "much better climate and a more honest situation." George reported that the HMA endorsed the measure and considers the present law "inconsistent with the personal liberties guaranteed by the Constitution." Satoru was more direct: "I feel that no non-Catholic physician can practice first-class, modern medicine under the archaic restrictions placed upon him by the current statute."

Bill Bergin, Catholic lay leader, felt that the emphasis on the mental condition of the mother was the "Pandora's box" of the problem. He protested that "killing the infant is not going to stop rape or incest, or the violation of the young or mentally defective. The remedy lies not in the killing of the infant, but in society's capacity to prevent or at least minimize such occurrences." Keith felt that enactment of the bill would be "a grave miscarriage of justice in that it will legalize murder." He said, "Perhaps the most shocking aspect of this bill is the attempt to legalize abortion for social reasons." Fred Dodge brought out that the Hippocratic Oath termed it wrong 400 years before Christ. "I know many women who had unwanted pregnancies, but I don't know a single woman with an unwanted child." Someone misquoted Fred's statement about the post-coital pill. In a Letter to the Editor, Fred carefully denied that he approved of the post-coital pill, even in rape cases.

## Conference Humor

Dynamic, personable medical historian and philosopher **Wesley Spink** was describing a noted female researcher who disagreed with him on a case of sarcoidosis vs. brucellosis. "She is a very remarkable woman, very talented and . . . fiery . . ." he said and, as if still recalling the ensuing torrent of verbiage, lowered his voice and bowed his head in meek submission.

He encouraged the audience to read the *New England Journal of Medicine*. . . . "I have no ax to grind . . ." he paused and added, "except they turned down two of my articles and wrote a scorching editorial about what I was doing."

Yet another philosophical quote by Wes: "Medicine is empirical. We cannot set up a protocol and expect residents and interns to follow."

Of pneumococcal pneumonia with its 40 per cent mortality in the elderly, he recalled William Osler's phrase "The old man's friend."

Overheard at a Queen's Derm conference: Dermatologist **Harold Johnson** was discussing with characteristic enthusiasm a case of atopic dermatitis associated with cataracts while the young Hawaiian woman with thick lenses fidgeted under the audience scrutiny. Noting that her dermatitis was under control, he asked patronizingly, "How is the skin condition now?" The woman replied, without malice, "It's much better since I started seeing a psychiatrist."

GI conference at Kuakini: Pedantic **George Suzuki** was moderating a postluncheon conference on pancreatitis. The enthusiastic Filipino intern who had done his homework well had just completed a 45-minute dissertation on the subject. Looking over the soporiferous audience, George asked softly, lest he awaken some of the listeners, "After that exhaustive dissertation, are there any further comments?" There were none.

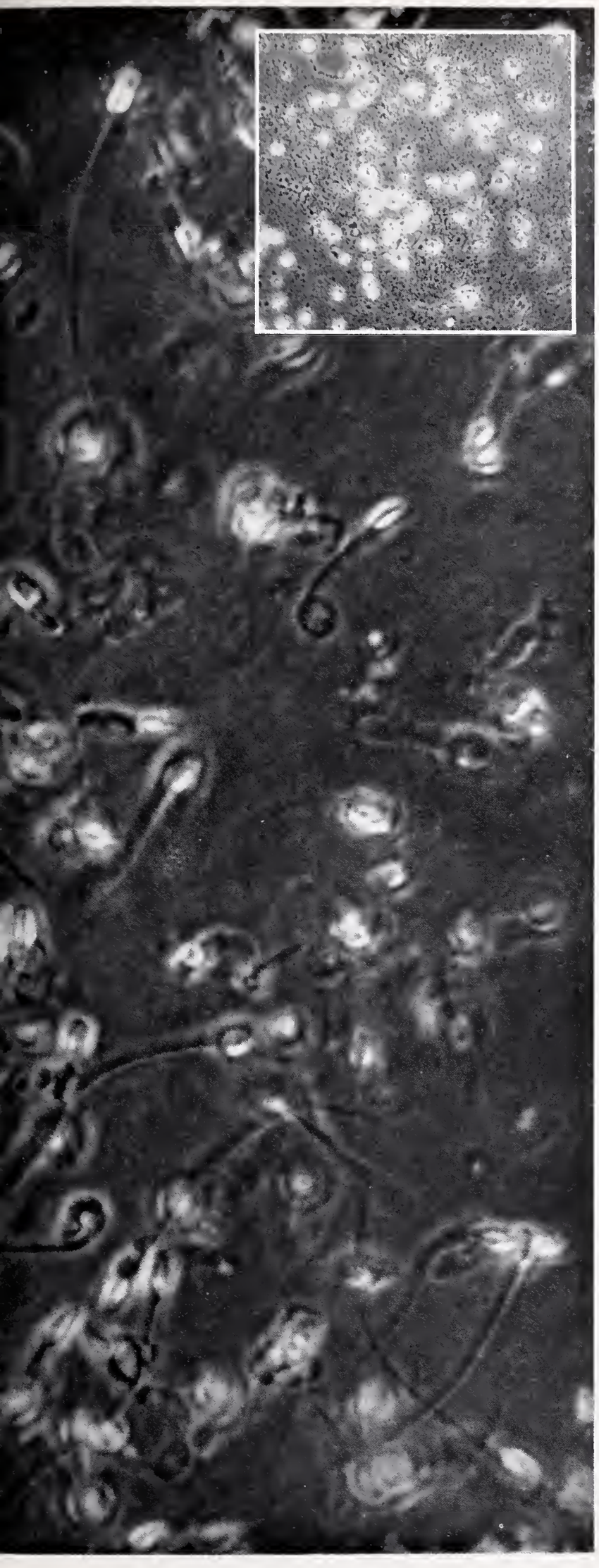
We were at the usually staid meeting of the Home Care Service at St. Francis Hospital when Sister Maureen spiced it with true Catholic taste. It seems that an enthusiastic male nurse was explaining at a Home Care meeting told how he had set up a bar for a semi-invalid patient. "There were a few raised brows until it was learned that this was a practice bar along the wall so the patient could practice walking." She commented with a twinkle in her eye.

## Elected, Appointed, and Honored

This item arrived via pony express. We just learned that **Bob Mookini** and **Masaru Koike** had passed their Boards in urology back in February last year. More recently, **George Kimata** got his Board certification in otolaryngology and **F. E. Popoff** his in psychiatry. On April 17, **Sam Buist** was installed as a Fellow of the American College of Obstetricians and Gynecologists at its annual meeting in Washington, D.C.

On the political front, the Governor recently appointed Big Islander **Ted Oto** to the Board of Medical Examiners, Maui pediatrician **Marion Hanlon** to the Commission on

*continued page 460*



# New view of an oral contraceptive at work

Although suppression of ovulation remains the primary mode of action of oral contraceptives, newer knowledge indicates that products like Norinyl-1—which provide the combined action of both low-dosage progestogen and estrogen for the full treatment cycle—offer multiple contraceptive action that helps explain their unexcelled record of effectiveness. This report explores the secondary protective mechanisms against unwanted pregnancy offered by combined hormonal administration and the importance of the progestational agent in making such multiple contraceptive action possible.

Accumulating evidence has indicated that sparse, highly viscous cervical mucus has an adverse effect on the motility and survival of spermatozoa.

The estrogen-opposing progestational ingredient of Norinyl-1 (norethindrone 1 mg. with mestranol 0.05 mg.) reverses the usual mid-cycle picture of a thin, watery cervical mucus. The result—a built-in barrier that inhibits sperm from reaching the ovum should one be released. The inset in the adjoining photograph shows immobile spermatozoa as they appear in cervical mucus taken from a patient treated with Norinyl-1.

See last page for contraindications, precautions, side effects and dosage.

# How the estrogen-opposing action of Norinyl-1 creates a hostile cervical mucus

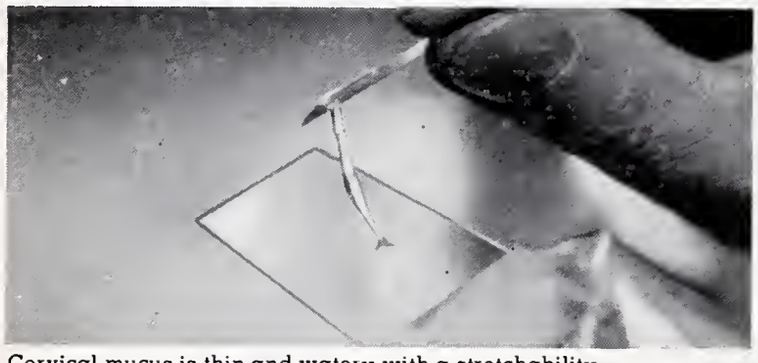
Normally estrogen activity during the fertile midcycle stimulates the production of cervical mucus. The mucus at this time is profuse and watery—allowing maximum sperm motility and promoting penetration.

But what happens when Norinyl-1 is administered? Its potent progestogen, norethindrone, opposes estrogen stimulation of cervical mucus. Consequently, the amount of mucus decreases and its viscosity increases. This results in a sparse but thick mucus barrier that diminishes the vitality of the sperm and impairs its powers of penetration.

## How hostile cervical mucus supports contraceptive action

The importance of these observations to the effectiveness of Norinyl-1 has been noted in a report on 89 patients taking this medication.* In all instances, cervical mucus obtained from cycle day 5 to cycle day 29 appeared scant and thick and exhibited little or no Spinnbarkeit. In the opinion of this investigator, the effect on cervical mucus may be sufficient to prevent conception. *Symposium on Low-Dosage Oral Contraception, Palo Alto, Calif., July 15, 1965.

### Normal cervical mucus at midcycle in untreated patient permits sperm motility... promotes sperm penetration.



Cervical mucus is thin and watery with a stretchability (Spinnbarkeit) of 15 to 20 cm.



Thin, watery mucus crystallizes into this well-defined, fernlike pattern within a minute.

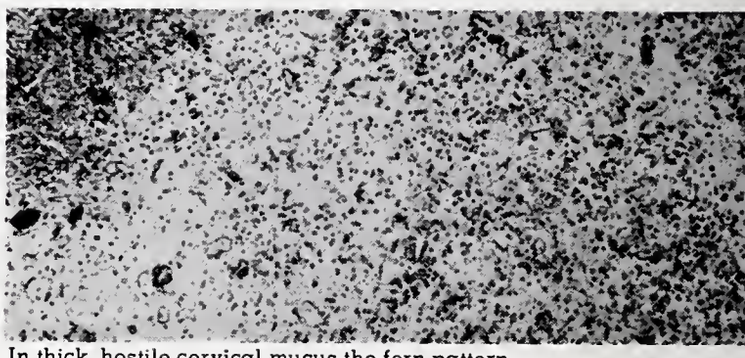


Spermatozoa appear healthy, are active and freemoving.

### Hostile cervical mucus at midcycle produced by Norinyl-1 impairs sperm vitality... inhibits penetration.



Cervical mucus is scanty, thick and viscous. Spinnbarkeit is 1 cm. or less.



In thick, hostile cervical mucus the fern pattern is poorly defined or absent.



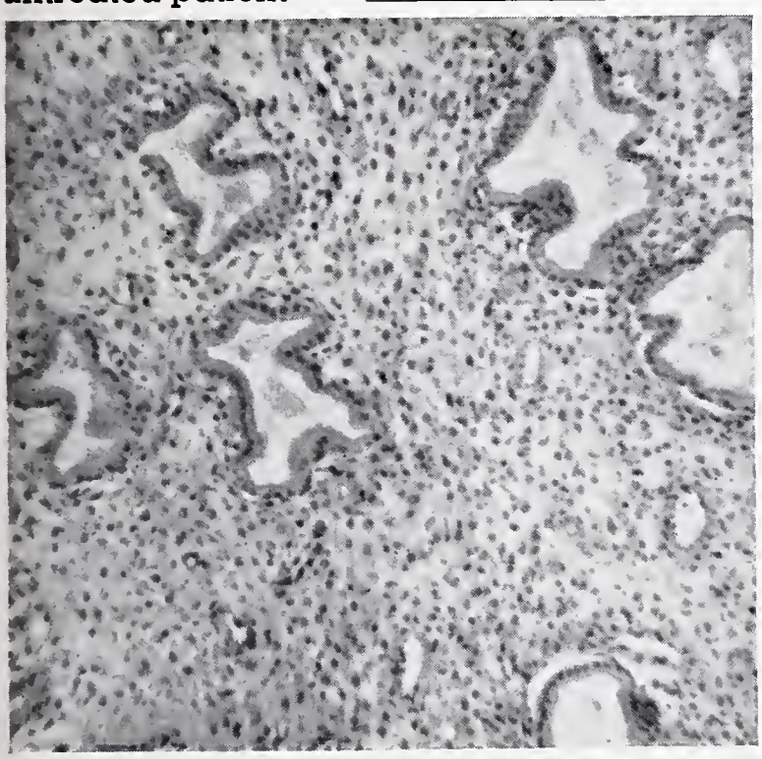
Immobile spermatozoa as they appear in cervical mucus taken from a patient treated with Norinyl-1.

# An endometrium unreceptive to nidation—another supporting contraceptive action of Norinyl-1

Let us suppose that an ovum is released—as occurs in an occasional, rare case—and somehow a sperm succeeds in penetrating the cervical mucus barrier? Should this come about, one additional action of Norinyl-1 may protect the patient from unwanted pregnancy—progestogen intake makes endometrial tissue unreceptive to implantation.

**Endometrium of untreated patient**

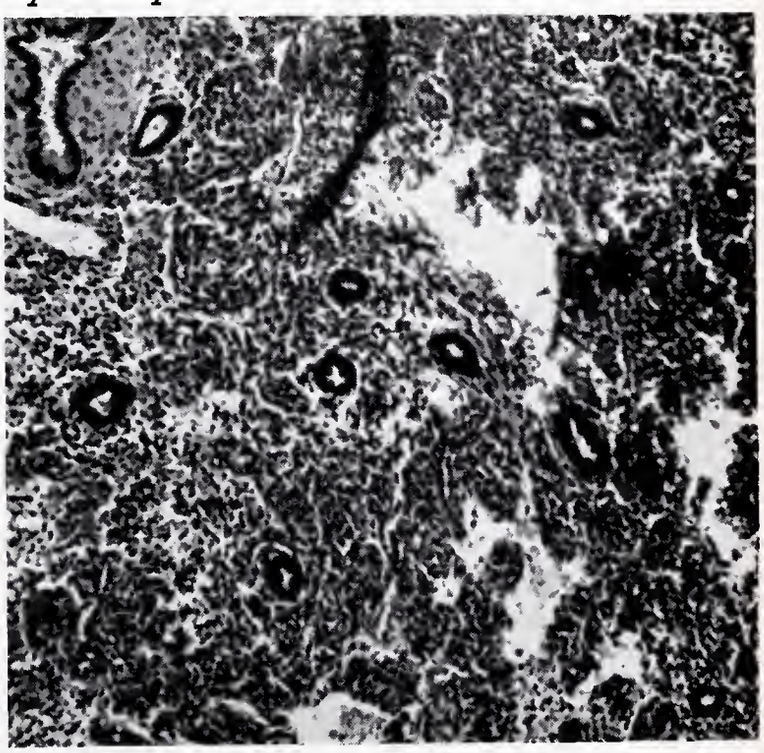




Normally the endometrium progresses through a proliferative phase stimulated by estrogen and a secretory phase stimulated by progesterone. During the secretory phase the endometrium is receptive to the fertilized ovum.

**Unreceptive endometrium produced by Norinyl-1**





When Norinyl-1 is administered its progestogen component—norethindrone—accelerates the secretory phase, suppressing glandular development. From day 11 on, secretory action is no longer present. The result is that during the latter half of the cycle the endometrium becomes unreceptive to egg implantation.

new Norinyl-1® tablets

(norethindrone 1mg ē mestranol 0.05mg)

See last page for contraindications, precautions, side effects and dosage.

# for multiple contraceptive action

## effective fertility control on half the previous dosage

## maintains ratio of the established norethindrone/mestranol combination

## lower cost

# new Norinyl®-1

(norethindrone 1mg. c̄ mestranol 0.05mg.) **tablets**

Reduction of oral contraceptive dosage to lowest effective levels has become a well-accepted principle of conservative medical practice. In keeping with this view, Norinyl is now available in a new strength in which *both* norethindrone and mestranol are reduced 50 percent. Studies show that Norinyl-1 achieves fertility control with only 1.05 mg. of combined progestogen and estrogen per tablet.

Norethindrone was first reported for use as a progestational agent in human beings in 1955. Norethindrone 2 mg. with mestranol 0.1 mg., as an oral contraceptive, is currently in use by over 2,000,000 women. Clinical experience now establishes that Norinyl-1 also amply meets the criteria of reliability and safety.*

*Symposium on Low-Dosage Oral Contraception, Palo Alto, Calif., July 15, 1965.

### PRESCRIBING INFORMATION

**Contraindications:** 1. Patients with thrombophlebitis or with a history of thrombophlebitis or pulmonary embolism. 2. Liver dysfunction or disease. 3. Patients with known or suspected carcinoma of the breast or genital organs. 4. Undiagnosed vaginal bleeding.

**Warnings:** 1. Discontinue medication pending examination if there is sudden partial or complete loss of vision or if there is a sudden onset of proptosis, diplopia, or migraine. If examination reveals papilledema or retinal vascular lesions, medication should be withdrawn. 2. Since the safety of Norinyl-1 in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods, pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule, the possibility of pregnancy should be considered at the time of the first missed period. 3. Detectable amounts of the active ingredients in oral contraceptives have been identified in the milk of mothers receiving these drugs. The significance of this dose to the infant has not been determined.

**Precautions:** 1. The pretreatment physical examination should include special reference to breast and pelvic organs, as well as a Papanicolaou smear. 2. Endocrine and possibly liver function tests may be affected by treatment with Norinyl-1. Therefore, if such tests are abnormal in a patient taking Norinyl-1, it is recommended that they be repeated after the drug has been withdrawn for 2 months. 3. Under the influence of estrogen-progestogen preparations, preexisting uterine fibroids may increase in size. 4. Because these agents may cause some degree of fluid retention, conditions that may be influenced by this factor, such as epilepsy, migraine, asthma, cardiac, or renal dysfunction, require careful observation. 5. Although a cause and effect relationship has not been established, Norinyl-1 should be used with caution in patients with a history of cerebrovascular accident. 6. In relation to breakthrough bleeding, as in all cases of irregular bleeding per *vaginam*, nonfunctional causes should be borne in mind. In cases of undiagnosed vaginal bleeding, adequate diagnostic measures are indicated. 7. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. 8. Any possible influence of prolonged Norinyl-1 therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. 9. A decrease in glucose tolerance has been observed in a small percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving Norinyl-1 therapy. 10. Because of the occasional occurrence of thrombophlebitis and pulmonary embolism in patients taking oral contraceptives, the physician should be alert to the earliest manifestations of the disease. A cause and effect relationship has not been demonstrated. 11. Because of the effects of estrogens on epiphyseal closure, Norinyl-1 should be used judiciously in young patients in whom bone growth is not complete. 12. The age of the patient constitutes no absolute limiting factor, although treatment with Norinyl-1 may mask the onset of the climacteric. 13. The pathologist should be advised of Norinyl-1 therapy when relevant specimens are submitted.

**Side Effects:** The following adverse reactions have been observed with varying incidence in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms, breakthrough bleeding, spotting, change in menstrual flow, amenorrhea, edema, chloasma, breast changes (tenderness, enlargement and secretion), loss of scalp hair, change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately postpartum, cholestatic jaundice, erythema multiforme, erythema nodosum, hemorrhagic eruption, migraine, rash (allergic), itching, rise in blood pressure in susceptible individuals, mental depression.

The following occurrences have been observed in users of oral contraceptives. A cause and effect relationship has not been established: thrombophlebitis, pulmonary embolism, neurooocular lesions.

The following laboratory results may be altered by the use of oral contraceptives: increased bromsulphalein retention and other hepatic function tests, coagulation tests (increase in prothrombin, factors VII, VIII, IX and X), thyroid function (increase in PBI and butanol extractable protein-bound iodine and decrease in $T^3$ values), metapyrone test, pregnanediol determination.

Other side effects reported to have occurred in association with use of this drug are dizziness, hirsutism, pains in legs, back, chest and abdomen, dysuria, drowsiness, vaginal discharge, libido increased and decreased, eruptions, hypermenorrhea, hypomenorrhea, increased appetite, G.U. infections, varicose veins, abdominal fullness, acne, headache, nervousness, allergies, blurred vision, pain in eyes, and itching in eyes. *For complete clinical data, see package insert.*

**Dosage and Administration:** 1. One tablet of Norinyl-1 is administered orally for 20 days beginning on day 5 of the menstrual cycle. (Count day 1 of the cycle as the first day of menstrual bleeding.) Repeat this dosage schedule for each cycle. 2. If no menstrual period occurs after a cycle of treatment (20 tablets) in which patient adhered to the schedule, the patient must be instructed to resume taking the Norinyl-1 tablets 7 days after the previous 20-day course was completed. For example, if the last pill of a previous cycle had been taken on a Sunday, then a new cycle of treatment should begin on the following Sunday. 3. In the postpartum woman, it is recommended that the first cycle of treatment should begin on day 5 of the first menstrual cycle. However, Norinyl-1 should not be administered during lactation.

**Availability:** Norinyl-1 (norethindrone 1 mg. with mestranol 0.05 mg.)—Dispensers of 20 and 60 and bottles of 250 tablets.

norethindrone — an original steroid from

SYNTEX LABORATORIES INC., PALO ALTO, CALIF.

# In Hawaii . . .
# This Syntex man serves the physician



Don Wright
Orinda, California
254-3607

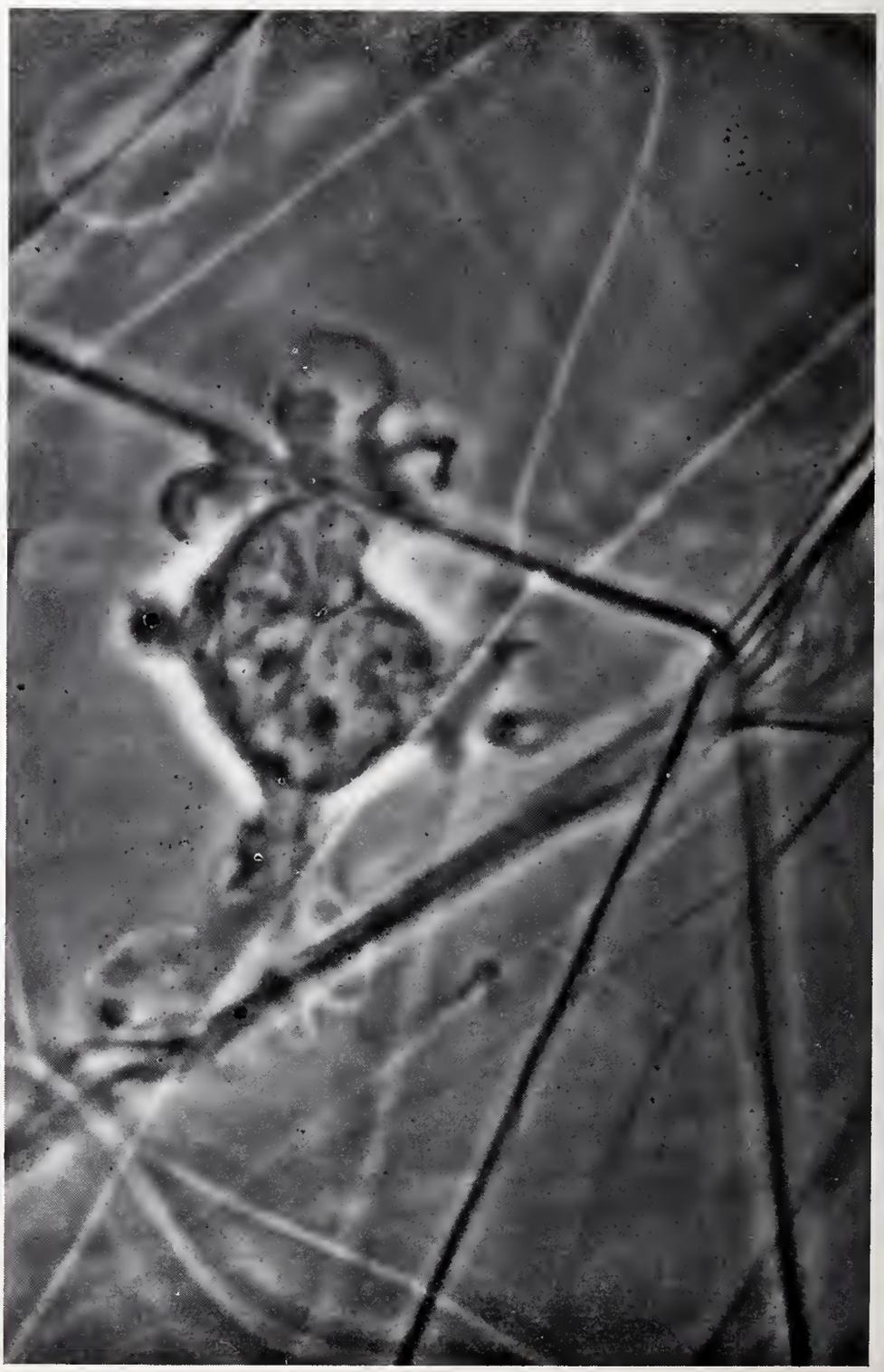
SYNTEX
LABORATORIES INC., PALO ALTO, CALIF

# INFLAMMATION:
# A cellular fight for life

*A SYNTEX REPORT based on recently developed hypotheses about topical corticosteroids, including the cellular theories of inflammation by Thomas F. Dougherty, Ph.D., University of Utah.*

You are looking at a fibroblast fighting for life. This cell—one of the most common found in connective tissue—has literally been poisoned by cytotoxins released from other cells that have ruptured. Soon, if the abnormal activity of this fibroblast does not cease, it, too, will rupture and die—one more casualty in the inflammatory wave of destruction precipitated by injury.

Until a short time ago no one had ever witnessed such a scene at the cellular level. Now, through advanced cinemicrographic techniques, it is possible to view and photograph the inflammatory process as produced experimentally in living animal tissue. This method permits new insight into the mechanism of inflammation and the role of corticosteroids in therapeutic management. Equally important, these techniques shed new light on factors that may make one corticosteroid more effective than another—factors that can be correlated with other chemical, biologic, and clinical parameters.

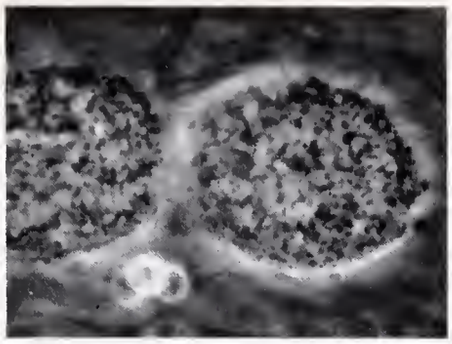


## Visual evidence of how corticosteroids influence the inflammatory reaction

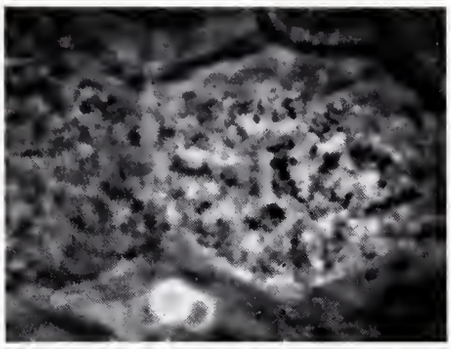
Working with phase-contrast cinemicrography on living animal tissue, Doctors Thomas F. Dougherty and David Berliner of the University of Utah College of Medicine have actually filmed cellular events that occur during the inflammatory reaction. This remarkable study* and additional work by these investigators, as well as by others, have established a new theoretical biologic basis for the antiinflammatory effect of the corticosteroids. (It must be noted that other theories, such as the lysosome or so-called "suicide bag" theory, have been postulated, although it is quite likely that there are more similarities than differences among the various theoretical models.)

## The inflammatory wave of destruction

In this investigation an injurious injection of gelatin is used to set off an inflammatory reaction in living mouse tissue. What follows is a wave of destructive cellular activity that comprises the inflammatory response to injury. Mast cells (which contain heparin, serotonin and histamine) take up water, swell and rupture, releasing their contents, which are toxic outside the mast cell wall. These toxins, in turn, cause disintegration of other cells (such as fibroblasts) and the release of additional toxic material. Capillaries, too, take up water and leak unformed blood elements, causing edema. And polymorphonuclears, lymphocytes and perithelial cells invade the inflamed site. As a result of all these changes, the cellular environment reaches a state of turmoil.



*Phase-contrast microscopy showing mast cell before injury.*



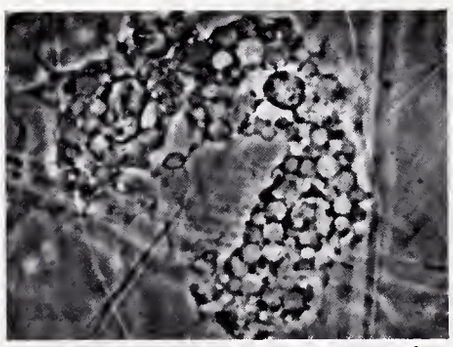
*Mast cell (after injury) has broken up and released cytotoxins.*

## How corticosteroids change the picture

Corticosteroids appear to virtually stop the abnormal cellular activity that constitutes the inflammatory reaction. This permits the body's natural resources to clear up the inflamed area and repair the damaged tissue. This interpretation is supported by the fact that when the injurious gelatin solution is injected simultaneously with a corticosteroid – Synalar (fluocinolone acetonide) – the inflammatory pattern simply does not develop.



*Fibroblast in high state of activity, much distorted.*



*Mast cells showing effects of corticosteroid action: cells are normal in size, shape and activity.*



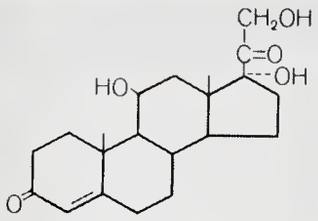
In summarizing his study Doctor Dougherty states: "...we also feel this work may explain why one corticosteroid helps a patient more rapidly and effectively than another. If it does, it is because one corticosteroid is the fastest, most effective inhibitor of the series of inflammatory events at the tissue level."

**A New View of Corticosteroid Action in Inflammatory Dermatoses,* a film based on this study, is now available from your Syntex representative.

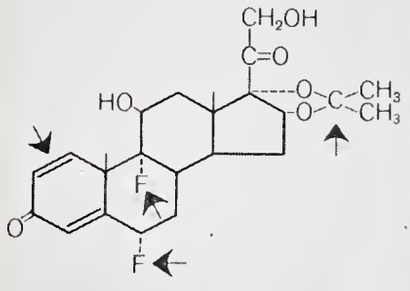
*See last page for contraindications, precautions, side effects and dosage.*

# How advances in chemical design have achieved greater steroid potency

The chemical modification of corticosteroid molecules from the advent of hydrocortisone to the development of Synalar (fluocinolone acetonide) is a prime example of how biochemists can "design" to increase therapeutic activity and minimize undesirable side actions. Below, for example, we see the important changes that were made in reference to the hydrocortisone molecule to produce fluocinolone acetonide, one of the most active of all topical corticosteroids. As a result, a 0.01% preparation of Synalar (fluocinolone acetonide) has been reported to do the work of a 1% hydrocortisone product containing 100 times more cortiscosteroid. And it can often do it more effectively.




**Hydrocortisone**

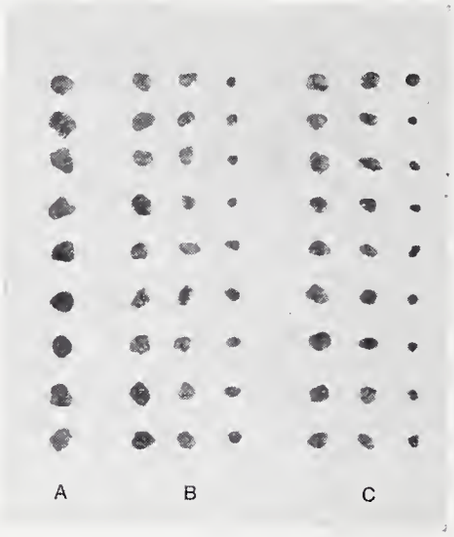



**Fluocinolone Acetonide (Synalar)**

- *a double bond between carbons 1 and 2*
- *fluorine substitutions at* both *the 6-α, and the 9-α positions*
- *the addition of the acetonide at the 16-α, 17-α positions, thus providing one of the most potent topical corticosteroids available.*

## How bioassay tests are used to "predict" therapeutic potential

Biologic assays are another tool used by researchers to help establish the relative activity of corticosteroids. To date no single method of assaying corticosteroid activity has emerged as the ideal "yardstick" for predicting therapeutic potential. Taken together, however, these methods have proved useful. When such tests are run on various corticosteroids, a definite order of corticosteroid activity becomes evident. Compounds with the highest order of activity may be expected to merit clinical trial to establish their high therapeutic potential. When assayed by these methods, fluocinolone acetonide (Synalar) emerges as one of the most active topical corticosteroids, milligram for milligram, available for clinical application today.




THE THYMUS INVOLUTION ASSAY[1-4] is run on adrenalectomized rats. The sizes of the glands are measured, and the degree of involution caused by the steroid is determined as an indication of its potency. In the above photo, the comparative involution of thymus glands achieved with hydrocortisone and Synalar (fluocinolone acetonide) is shown. Untreated controls (A) show normal size. Group B – injected with 1, 2 and 4 mg. of hydrocortisone – show progressively smaller thymuses as does Group C – injected with fluocinolone acetonide – but with only 1/500th the dose of hydrocortisone.




THE ANTIGRANULOMA ASSAY[1-4] also utilizes adrenalectomized rats. Granulomas are induced by subcutaneous implantation of cotton pellets on either side of the thorax. The degree of granuloma inhibition achieved by a steroid reflects its potency. The above photo shows the inhibition of granuloma formation achieved with hydrocortisone and Synalar (fluocinolone acetonide). Untreated controls (A) show large, red granulomas adhering to the pellets. Group B, receiving hydrocortisone and Group C, receiving fluocinolone acetonide, show little, if any, granuloma formation. Fluocinolone acetonide produced the same effect as hydrocortisone with only 1/500th the dose. This assay, as well as the thymus involution assay, measures systemic rather than topical corticosteroid activity. Nevertheless, results by these methods correlate well with other assays and with the milligram potencies of topical steroids in current clinical use.

# Worldwide clinical experience confirms the predictable therapeutic potential of Synalar

It is particularly gratifying that the promise of the advanced chemical design and high order of bioassay activity of Synalar (fluocinolone acetonide) has been confirmed by widespread therapeutic application. Indeed, the impressive clinical response rate of Synalar has been documented in no fewer than 232 papers from 22 countries.

**Representative Clinical Results with Synalar***

**Efficacy Documented in over 4,000 Patients**

| Condition | Number of Publications | Number of Patients | Significant Improvement† |
|---|---|---|---|
| Contact Dermatitis | 27 | 750 | 713 |
| Eczematous Dermatitis | 21 | 472 | 409 |
| Seborrheic Dermatitis | 18 | 442 | 426 |
| Atopic Dermatitis | 24 | 460 | 426 |
| Psoriasis | 36 | 1,699 | 1,510 |
| Neurodermatitis | 18 | 351 | 324 |
| Total | 144 | 4,174 | 3,808 |

*Complete bibliography on request.

†Expressed by the authors as excellent, very good, good, complete remission of inflammation, etc.

PRESCRIBING INFORMATION

*For initiation of therapy:* Cream 0.025%, 5 and 15 Gm. tubes, 425 Gm. jars; *for emollient effect:* Ointment 0.025%, 15 Gm. tubes; *for maintenance therapy:* Cream 0.01%, 15 and 45 Gm. tubes, 120 Gm. jars; *for intertriginous or hairy sites:* Solution 0.01%, 20 cc. and 60 cc. plastic squeeze bottles; *for infected inflammatory dermatoses:* Neo-Synalar® Cream (0.025% fluocinolone acetonide, neomycin sulfate, equivalent to 0.35% neomycin base), 5 and 15 Gm. tubes. CONTRAINDICATIONS: Tuberculous, fungal, and most viral lesions of the skin, (including herpes simplex, vaccinia, and varicella). Not for ophthalmic use. Contraindicated in individuals with a history of hypersensitivity to any of the components. PRECAUTIONS: Synalar preparations are virtually nonsensitizing and nonirritating. However, the solution may produce burning or stinging when applied to denuded or fissured areas. In some patients with dry lesions, the solution may increase dryness, scaling or itching. While topical steroids have not been reported to have an adverse effect on pregnancy, the safety of their use on pregnant females has not absolutely been established. Therefore, they should not be used extensively on pregnant patients, in large amounts, or for prolonged periods of time. Prolonged use of any antibiotic may result in overgrowth of nonsusceptible organisms; if this occurs, appropriate therapy should be instituted. When severe local infection or systemic infection exists, the use of systemic antibiotics should be considered, based on susceptibility testing. SIDE EFFECTS: Side effects are not ordinarily encountered with topically applied corticosteroids. As with all drugs, however, a few patients may react unfavorably to Synalar under certain conditions. The neomycin in Neo-Synalar Cream rarely produces allergic reactions.

REFERENCES: 1. Lerner, L. J., Bianchi, A., Turkheimer, A. R., Singer, F. M., and Borman, A.: Anti-inflammatory steroids: potency, duration and modification of activities. Ann NY Acad Sci 116:1071 (Aug. 27) 1964. 2. Idem: Comparison of anti-granuloma, thymolytic and glucocorticoid activities of anti-inflammatory steroids. Proc Soc Exp Biol Med 116:385 (June) 1964. 3. Ringler, A.: Activities of adrenocorticosteroids in experimental animals and man, in Dorfman, R. I.: Methods of hormone research, New York, Academic Press, 1964. vol. III. pp. 234-280. 4. Gubersky, V. R.: To be published.

fluocinolone acetonide—an original steroid from

SYNTEX LABORATORIES INC., PALO ALTO, CALIF.

**For inflammatory dermatoses... by any measure a topical corticosteroid of choice**

# Synalar® (fluocinolone acetonide)

*Milligram for milligram one of the most active topical corticosteroids available*

*Rapid and predictable in antiinflammatory and antipruritic activity*

*Results often comparable to those of systemic corticosteroids with fewer hazards*

# HAWAII TECHNOLOGISTS' BULLETIN

*Official Publication of the Hawaii Society of Medical Technologists*

*Editor:* LOUISE WULFF, MT(ASCP), University of Hawaii

## *Automation—Continued*

FROM THE PRIVATE REFERENCE LAB

The following report is from Mrs. Dorothy Matsuo who recently returned from a two-week training session at the Technicon Company. There she and Dr. Belles had a chance to become acquainted with the SMA 12, the same model that is being installed in Pathology Associates' main laboratory.

They also saw a demonstration of the hematology model, the SMA 4, and of the research model for agglutination techniques.

Mrs. Matsuo is Chief Technologist at Pathology Associates Medical Laboratories and Dr. Quentin Belles heads the Division of Chemistry there.

Dr. Quentin Belles and I discussed the future of medical technologists at a 39,000 foot level, since we were "jetting" into the Ardsley, New York, headquarters of Technicon Co.

Without a doubt, the routine clinical laboratory will be successfully automated in two or three years in every area, with the exception perhaps of work involving the microscope.

The automation equipment for single channel chemical analysis has long been available but the emphasis is now on the sequential multiple analyses. It is almost unbelievable that you can feed a sample into the machine and after ten minutes start reading off values for 12 determinations. The chemistry technologists know that it takes at least ten minutes just to organize the work sheet that says who is to have what done and they still occasionally miss an order. Precipitates, funnels, pipets, and cuvets will soon be things of the past, replaced by pump tubing, nipples, coils, debubblers, etc.

Automation equipment for hematology is now available also. A single sample is split four ways, two leading to a cell count for the red and white count, another leading to the colorimeter for the hemoglobin and the last leading to a conductance bridge to determine the hematocrit by electrical conductance. All four determinations feed into a programmer which relates the information to the recorder in proper sequence.

Various automated serologic reactions were being perfected in the research laboratories at Technicon, and blood typings, crossmatchings, complement fixations, and other agglutination studies by automation will soon be a reality.

How will all of this affect the technologists of today and the preparation of those of tomorrow? The technologist who can acquire the higher level of skills in complicated procedures will do so, and elevate her status as a professional. She will use automation to free herself to do the more complicated procedures. To help the technologists in Hawaii toward this end, HSMT must assume the responsibility, together with the University of Hawaii, of providing various postgraduate courses.

The technologists of tomorrow should possesses either five-year certificates or Master's degrees. In the training program of the technologists, more emphasis must be made on physics, electronics, ing a professional science.

Medical technology is truly on its way to becom- advanced biochemistry and hematology, and statistical analysis.

## *Graduate Education*

Along about the end of August or the first of September most everyone thinks about returning to school. For the student, this is reality; for the long-range grad, it is a sort of dream—a vague longing for intellectual stimulation with a large amount of the wish to return to the good old days of one's youth. But it's time to get off the dream kick and face up to the facts of today's professional needs. So if you've faced reality, stopped dreaming, and decided to go back and get that M.S., *now* is the time to apply for admission to graduate school. To assist you in making a choice, here is a list of possible schools. The University of Hawaii has a plan for a Master's in Pathology which will include a program for Med Techs. This has not been scheduled at this writing. However, it is possible that students will be accepted by the fall of 1967.

### GRADUATE COURSES IN MEDICAL TECHNOLOGY OFFERING M.S. DEGREES

A. *For MT (ASCP)s with baccalaureate degrees:*

1. University of Alabama Medical Center, Birmingham, Ala., Department of Clinical Pathology, offers Master of Science in Clinical Laboratory Science for medical technologists (stipends for tuition and fees provided under three-year PHS Grant in 1966).

2. University of Colorado Medical Center, Denver, Colo., offers an M.S. in laboratory medicine. Active program only in clinical chemistry. Will include other areas at a later date.

3. Marquette University School of Medicine, Milwaukee, Wisc., offers M.S. and Ph.D. degrees in Department of Pathology's Graduate School.

4. University of Minnesota Graduate School, Minneapolis, Minn., offers an M.S. in medical technology.

5. University of Nebraska College of Medicine, Omaha, Nebr., is planning a program to start in 1967 for an M.S. in pathology for medical technologists.

6. State University of New York, Upstate Medical Center, Syracuse, to start in 1967 to offer an M.S. in medical technology.

7. Northwestern University Medical School, Chicago, accepts MT (ASCP)s in course listed under B-1 with flexible program, requiring some research, thesis, etc., and more administrative and teaching experience.

8. Ohio State University, Columbus, Ohio, gives M.S. and Ph.D. degrees in clinical pathology to medical technologists under Department of Pathology, Clinical Laboratories, University Hospital, under five-year grant began in 1966 for Graduate Training Program in medical technology. Trainee stipends and fees are given for medical technology master's training program.

9. University of Oregon Medical School, Portland, Oregon, offers an M.S. in medical technology.

10. University of Pennsylvania, Philadelphia, is planning a graduate program for medical technology, but starting date is unknown at this time.

11. C. W. Post College of Long Island University, Greenvale, N. Y., offers an M.S. in biology with concentration in medical technology areas.

12. Temple University School of Medical Technology, Philadelphia, Pa., offers an M.S. in medical technology with specialization in hematology, biochemistry, or bacteriology, plus a separate program in teaching and supervision for persons with at least five years teaching experience.

13. University of Tennessee, College of Medicine, Memphis, gives an M.S. in medical technology.

14. West Virginia University, Morgantown, has an M.S. program leading to a graduate degree with emphasis in Health Education and Medical Technology.

B. *For persons who have baccalaureate degree without MT (ASCP) training:*

Several institutions offer the regular AMA-Accredited Medical Technology training in an advanced level program offering a Master's degree in medical technology. Chief among these are:

1. Northwestern University Medical School, Chicago, the course is for a minimum of 21 months; last nine months in research project, thesis, and intensive administrative experience.

2. Texas Christian University, Fort Worth, Texas, in affiliation with Harris Hospital School of Medical Technology.

3. Wayne State University Graduate Division, Detroit, Michigan, in affiliation with Henry Ford Hospital School of Medical Technology.

In addition, many accredited institutions give Master's degrees and doctorates in microbiology, biochemistry, biology, hematology, chemistry, and other sciences for which MT (ASCP)'s who have acceptable baccalaureate degrees may become candidates.

Some MT (ASCP) Teaching Supervisors take Master's degree programs in education to study methodology, tests and measurement, educational psychology, curriculum development, and similar subjects which will be valuable to them as medical technology educators. Others who may plan to work primarily in supervisory and administrative areas, may secure advanced degrees in personnel management, hospital administration, or similar areas. ■

*"YOUNG FEET DESERVE THE BEST"*

**ANNOUNCEMENT**

*Hawaii's only children's shoe store—now in its 17th year of service to the community—has moved to its new location.*

**SPECIALISTS—SABEL'S ORTHOPAEDIC SHOES REGULAR SHOES**

**Surgical — Equino-Varus — Straight Last**
**Denis Browne Splints — Freidman Counter Splints**

**TEENY TOTS' FOOTWEAR**
Investors' Finance Building

1111 Bishop St., Honolulu Telephone 586-163

Children and Youth, **Cesar De Jesus** to the Board of Health, and **George Suzuki** to the Commission on Aging.

The Kauai GOP Committee recently endorsed **Yone Miyashiro** for the Mahelona Hospital Board of Trustees, **Marvin Brenneeke** and **Patriek Coekett** for the County Advisory Health Committee. With the indumbent [we couldn't bring ourselves to change that spelling!—ED.] Democratic regime, we wish these fellows all the luck.

The Foundation for Medical Care reelected **George Mills** President. **O. D. Pinkerton** was elected vice president, **Fred Warshauer,** treasurer, and as directors **Keith Kuhlman, Ted Tomita, John Lowrey, William Dang, Paul Tamura,** and **K. S. Tom.**

The HMSA elected **J. A. Burden** of Maui as a new director, and reelected **Robert Katsuki, Douglas B. Bell,** and **Howard Crawford. William Moore** replaced **Robert Katsuki** as secretary. Go-getter **Raymond Wong,** after his successful campaign as Cerebral Palsy Campaign chairman, was elected vice president of the Honolulu Chinese Jaycees.

## Travelers and Social News

The Art For Heart's Sake benefit auction in March tallied $29,590 for the paintings and sculptures offered. This fell short of last year's total of $30,175. Philanthropist **Phil Lee** paid $2,975 (the second highest bid of the evening) for **Peter Hayward's** "Haiku from Kahaluu." **Gordon Diekie** paid $1,250 for Hiroshi Tagami's "Come Walk With Me." Likable **Unoji Goto,** President of the Heart Association, explained that the annual fund-raising event provided money for research, scholarships, educational programs, and free medication.

We learned that **John Roberts,** physician, anesthesiologist, quondam medical columnist, and surfer extraordinary, is also a talented pianist. He was guest performer at the Morning Music Club program in March and played a Schumann sonata, a Ravel sonatina, and a Rameau gavotte. (Did we get that right?) John studied piano at the New England Conservatory of Music, and gave a concert at the Honolulu Academy of Arts in 1963. Perhaps he could find some spare time in his 36-hour day to write "Hawaii Doctor" again.

The Year of the Ram got off to a cracking start at the mezzanine floor of the Royal Hawaiian for the 18th Annual Narcissus Coronation Ball. Most Eligible Bachelor **Walton Shim** was photographed in an animated discussion with a Miss Carolyn Chun and the caption read with typical society reporter candor, "Neither a tray of blooming narcissus flowers nor an original sequinned lace evening dress in jonquil yellow by Richard Tam takes Dr. Walton Shim's mind off the talk he is having. . . ." **Diek Lam** and his six sisters gave a birthday party with 600 guests at the Hilton Dome for his mother, Mrs. Charles Wing Chow Lam, on her 71st birthday.

Having tasted the products of Hazel Okazaki's Japanese culinary talents, we were quite envious of **Joe Nishimoto,** who bid successfully for her dinner for ten at the recent Honolulu County Medical Society Woman's Auxiliary's "silent auction" at the Hilton Hawaiian Village. Alberta Yamada and Florence Goto co-chaired the event, and Terry Lee and Alice Fukunaga took reservations for the highly successful affair. Hazel has been compiling a book on Japanese cooking and we entreat her to publish it before long.

## Community Notes

Generous **Diek Sakimoto** contributed $10,000 to the Kuakini Hospital Modernization and Development Fund. Dick is chairman of the medical staff division of the drive and has received doctors' pledges totaling $105,000. Contributions toward the $1 million goal, however, is at a paltry $470,000 as of March 1. We feel that more Dick Sakimotos, with $10,000 checks, are needed.

**Hunky Chun,** President of the Honolulu Chorale, and wife, Alberta, entertained the 84 members of the Chorale at a post-concert party at their delightful Mauna Place home. After singing two hours before a capacity audience in Dillingham Hall, the group still had voice enough to make the surrounding hills reverberate with their vocalizing. Luckily they have good neighbors.

Attractive Yun Soong Jim, wife of **Vernon Jim** and mother of four daughters, was selected as Hawaii's outstanding high school biology teacher for 1967. Yun Soong was honored at the April 22 annual meeting of the Hawaiian Academy of Sciences and presented with several awards, including a $600 binocular microscope.

We congratulate the "world known isle neurosurgeon" for remaining incognito in a recent article by Tomi Knaefler about three patients from far-flung corners of the world who came to Honolulu to have anterior cervical laminectomies. A "Letter to the Editor" several days later read as follows: "Why wasn't the prominent physician of Honolulu named in the recent article by Tomi Knaefler?" "Editor's Note: The Hawaii Medical Association exerts strict supervision over personal publicity by and for its members. We felt the neurosurgeon's name should have been a part of the story, but left it out so as not to stir the professional jealousy of his colleagues." Wot rot! Our poor editors still misunderstand our news code, it seems. But then, it's sort of muddled in our minds too.

Enterprising **Shig Horio** was the first to correctly diagnose the *Beacon's* "Who's Who in Hawaii" for December 1966; he won an evening of fine dining for two at M's Ranch House.

The Westsiders on Kauai, alerted by **Yone Miyashiro,** were alarmed about the future of the Kauai Veterans Memorial Hospital and were up in arms trying to upgrade their hospital. The target of their criticism was the Health Advisory Council's report which suggested that Wilcox Memorial be made the island's health center. With infighter Yone in there pitching, we can expect action. ■

**MEDICAL INDUSTRIES, LTD.**

**949 McCully Street, Room 11** **Phone 990-396**

ZIMMER

HALLMARK

STRYKER

MILTEX

MISDOM-FRANK



# is Jane stubborn?

Well, a little perhaps. But she has reason on her side. As head of the Coagulation Research Unit at the Warner-Lambert Research Institute, Mrs. Jane Lenahan prepares and tests a great many coagulation reagents. Ours and others. Some that are commercially available and some purely experimental. With all her long experience, she's never changed her mind about one thing: Simplastin comes closest to the ideal standards for a thromboplastin reagent.

If Jane could show you through her laboratories, she'd point out the sound theoretical and practical basis on which the superior performance of Simplastin® is built. To achieve the utmost sensitivity, stability and reproducibility, Simplastin is made from a carefully controlled blend of brain and lung tissue. In a painstaking process never duplicated by any other manufacturer, these starting materials are purified and adjusted to assure optimum pH, particle size and number in the final product.

Equally as important as the things that go into Simplastin are those left out – no moisture, no artificial stabilizers (which could lengthen the patient's prothrombin time) and, of course, not even the least trace of blood (which would affect factor VII and X sensitivity). As a result, Simplastin is sensitive and reproducible, not only with normal plasma but where it counts the most: with dilute plasma and plasma from patients on anticoagulant therapy.

Sometimes, it pays to be just a little bit stubborn....

GENERAL DIAGNOSTICS Division Warner-Chilcott Laboratories, Morris Plains, N.J.

phies are awarded to the outstanding medical assistant of the year—the awards being The President's Trophy, Junior Medical Assistant of the Year, and Medical Secretary of the Year. It is noted that various organizations have donated trophies and the BME would like to know whether they could prevail upon the HMA to consider donating the "Junior Medical Assistant of the Year" trophy.

**ACTION:**

**It was voted to donate $25.00 to the Bureau of Medical Economics for a trophy to be awarded to the Junior Medical Assistant of the Year.**

*Letter from the Hawaii State Health Council:* A letter from the Hawaii Health Council requesting continuation of financial support was circulated.

It was pointed out that the Hawaii State Health Council was originally the Oahu Health Council. It was noted that the HMA contributed $100 to the Oahu Health Council in 1966. It was pointed out that the Honolulu County Medical Society and the Hawaii Heart Association voted not to support Hawaii State Health Council. The American Cancer Society, Hawaii Chapter, is in favor of the idea to get it off the ground. It was noted that they do not have enough funds to work out a good program. It was suggested that they not be supported since they are having difficulty in finding a solid purpose.

**ACTION:**

**It was voted that the Council go on record not to support the Hawaii State Health Council financially at this time but that a letter be sent to them asking that they fully explain their activities and how the activities will not be in conflict or reduplication of present laws, and that a reply be available to the House of Delegates at the time of the Annual Meeting in May.**

*Letter from V. Thomas Rice:* Mr. Rice's letter was reviewed in which he proposed that he "should prepare a communication to all members pointing out and emphasizing the necessity that all members supervise their billing practices so that they are in a position to meet the growing demands that they can statistically demonstrate to third parties their true, usual and customary charge for services. My estimate for my charge for preparation of this communication is $100."

Dr. Tomita stated that Mr. Rice has visited each county relative to the Workmen's Compensation Fee Schedule, and that these trips were very revealing and very educational. Mr. Rice has lots of suggestions to make from a legal standpoint. He pointed out that the opinion rendered by Mr. Rice would be worthwhile for the future of the medical profession in the State of Hawaii. It was pointed out that the request of $100 for communications and the balance of $350 for plantation corporate practice does not require action from the Council. The Council is asked to give its approval to have information obtained from Mr. Rice circulated to the HMA membership.

**ACTION:**

**It was voted to accept Mr. V. Thomas Rice's offer to circulate and publish information to the HMA membership.**

*Request from the Commission on Medical Services:* On February 20, 1967, the Commission on Medical Services voted to stop negotiations with HMSA and to send a letter to the HMA membership advising them step by step of the transactions. The Commission is asking guidance from the Council re this matter. It was pointed out that there was some difficulty in determining by the HMA staff just what was required to be sent out. It was pointed out that Kauai County would like negotiations to con-

*continued page 464*




THE ONLY QUESTION THIS YEAR IS: WHICH CADILLAC?

*See all the exciting new Cadillac models at* **SCHUMAN'S**

*1234 South Beretania Street*

# THREE TIMES A YEAR

*Your patients without a plan to economically protect them when they are in need of medical assistance may join Hawaii's own community service medical plan on an individual basis three times a year.*

*Membership is open to qualified individuals of all ages in*

MARCH — JULY — *and* — NOVEMBER

*HMSA is a non-profit, community service organization. As such it is able to provide tremendous benefits for reasonably low dues.*

*HMSA is the medical plan which gives you free choice of doctors and hospitals — an extremely desirable feature.*

Member of Western Conference of Prepaid Medical Service Plans




® BLUE SHIELD PLAN FOR HAWAII

## HAWAII MEDICAL SERVICE ASSOCIATION

*For More than 28 Years — Hawaii's Own / Hawaii Owned*

tinue with HMSA, Maui County would not like to continue negotiations, and no answer has been received from Hawaii County. It was felt that the counties should be informed so that they can instruct their delegates on how to vote at the House of Delegates meeting.

A letter from a member of the Association was reviewed. The letter states that there is a lack of communication between the leadership of the Association and Societies and the membership. It was pointed out that all county presidents receive minutes of all committee meetings and, in addition, they received a letter dated February 28, 1967, which reported the present status of the negotiations between the HMA and HMSA. It was suggested that this physician be asked to explain to the delegates what he means by "lack of communication."

It was recommended that a letter be written to the member stating that a communication has been sent out re HMSA status previously and since he is a member of the House of Delegates further information can be obtained at that time.

**ACTION:**

**It was voted that the action of February 20, 1967, by the Commission on Medical Services be carried out.**

**SECRETARY'S REPORT**

The Secretary's seven recommendations were discussed and acted upon as follows:

**ACTION:**

**It was voted to approve the membership changes reported by the counties and that the roster of the HMA be set as indicated in the Secretary's Report for March, 1967.**

**It was voted that a letter be sent to each county society asking what their bylaws state with reference to payment of the current year's dues by members who transfer from other state associations and that this information be reported back to the Council at its next meeting.**

**It was voted that inasmuch as Dr. Carvalho did not receive membership benefits for which he paid in 1966 that his dues be prorated and that he be refunded one-quarter of his 1966 HMA dues and one-half of his Journal subscription fee.**

**It was voted that Dr. Adams' HMA dues for 1966 be waived inasmuch as he was a transfer from another state.**

**It was voted that Drs. Goff and Lee be billed for their HMA dues and Journal subscription on the basis of one-quarter of 1966, and that the nontransmittal of AMA dues be waived.**

**It was voted that the follow-up of the counties who have not replied relative to nonaffiliated members not be pursued in view of the PR Committee's questionnaire.**

**It was voted that 1968 Annual Meeting be held in Honolulu during the week of May 22-25, 1968, and that the House of Delegates be requested to give the Council the Authority to change these dates if it finds such a change advisable.**

**It was voted that a full discussion of membership classifications be undertaken by the Council at its next meeting and that direction be given the Bylaws and Parliamentary Committee to develop changes which will reflect the Council's position.**

**TREASURER'S REPORT**

The Treasurer's Report was discussed and acted upon as follows:

*continued page 468*



These glasses are important to him—in his work, socially, and in terms of his physical well-being.

When's the last time you had an eye check? Schedule an appointment soon with your eye physician.

OBRIG Contact Lenses fitted by prescription. We are GUILD OPTICIANS, serving Hawaii since 1939.

GUILD OPTICIANS

**OPTICAL DISPENSERS**

**of Hawaii, Inc.**

| | |
|---|---|
| **1133 BISHOP ST.** | **576-570** |
| **312 ALA MOANA BLDG.** | **976-925** |
| **PROFESSIONAL CENTER BLDG., KAILUA** | **256-030** |

**MEDICAL PLACEMENT BUREAU and NURSES' REGISTRY**

24 Hour Service

**LET US SERVE YOU IN YOUR NEED**

Nurses, Staff and Office
Nurses, Private Duty
Nurses, Supervisors
Practical Nurses
Nurses, Aide
Dental Assistants
Physical Therapists
X-Ray Technicians
Laboratory Technicians
Medical Stenographers
Medical Clerks
Receptionists
Male Nurses
Bookkeepers
Home Companions

Frieda M. Beezley, R.N., *Director*

**1473 South King St.** **991-237**




*TIMING THE SPACE AGE...*

# Ω OMEGA

*the watch that orbited in outer space with American Astronauts*

We are proud that the watch we recommend above all others...Omega...was selected by the National Aeronautics and Space Administration for standard issue to all astronauts in the history-making Gemini program.

A—Omega 2-button, 4-dial Speedmaster wrist-computer. Measures elapsed intervals of time. Ideal for technical timing needs ..$185

B—Omega self-winding, date-telling, Seamaster De Ville .....$120

*Nothing down take a year to pay*

**SECURITY DIAMOND** **CONRAD JEWELS**

HAWAII

HAWAII'S LEADING JEWELERS

ALA MOANA CENTER • DOWNTOWN • HILTON HAWAIIAN VILLAGE • THE ILIKAI HOTEL

# In managing tense, anxious patients here's one combination that makes sense: your understanding counsel and **Serax**®

(oxazepam) Wyeth

When prescribing, carefully observe dosage recommendations and appropriate precautions, especially as pertaining to the elderly (see Wyeth literature or PDR as well as "IN BRIEF" below).

**IN BRIEF.**

**Contraindications:** History of previous hypersensitivity to oxazepam. Oxazepam is not indicated in psychoses.

**Precautions:** Hypotensive reactions are rare, but use with caution where complications could ensue from a fall in blood pressure, especially in the elderly. Withdrawal symptoms upon discontinuation have been noted in some patients exhibiting drug dependence through chronic overdose. Carefully supervise dose and amounts prescribed, especially for patients prone to overdose; excessive, prolonged use in susceptible patients (alcoholics, ex-addicts, etc.) may result in dependence or habituation. Reduce dosage gradually after prolonged excessive dosage to avoid possible epileptiform seizures. Withdrawal symptoms following abrupt discontinuance are similar to those seen with barbiturates. Caution patients against driving or operating machinery until absence of drowsiness or dizziness is ascertained. Warn patients of possible reduction in alcohol tolerance. Safety for use in pregnancy has not been established.

Not indicated in children under 6 years; absolute dosage for 6- to 12-year-olds not established.

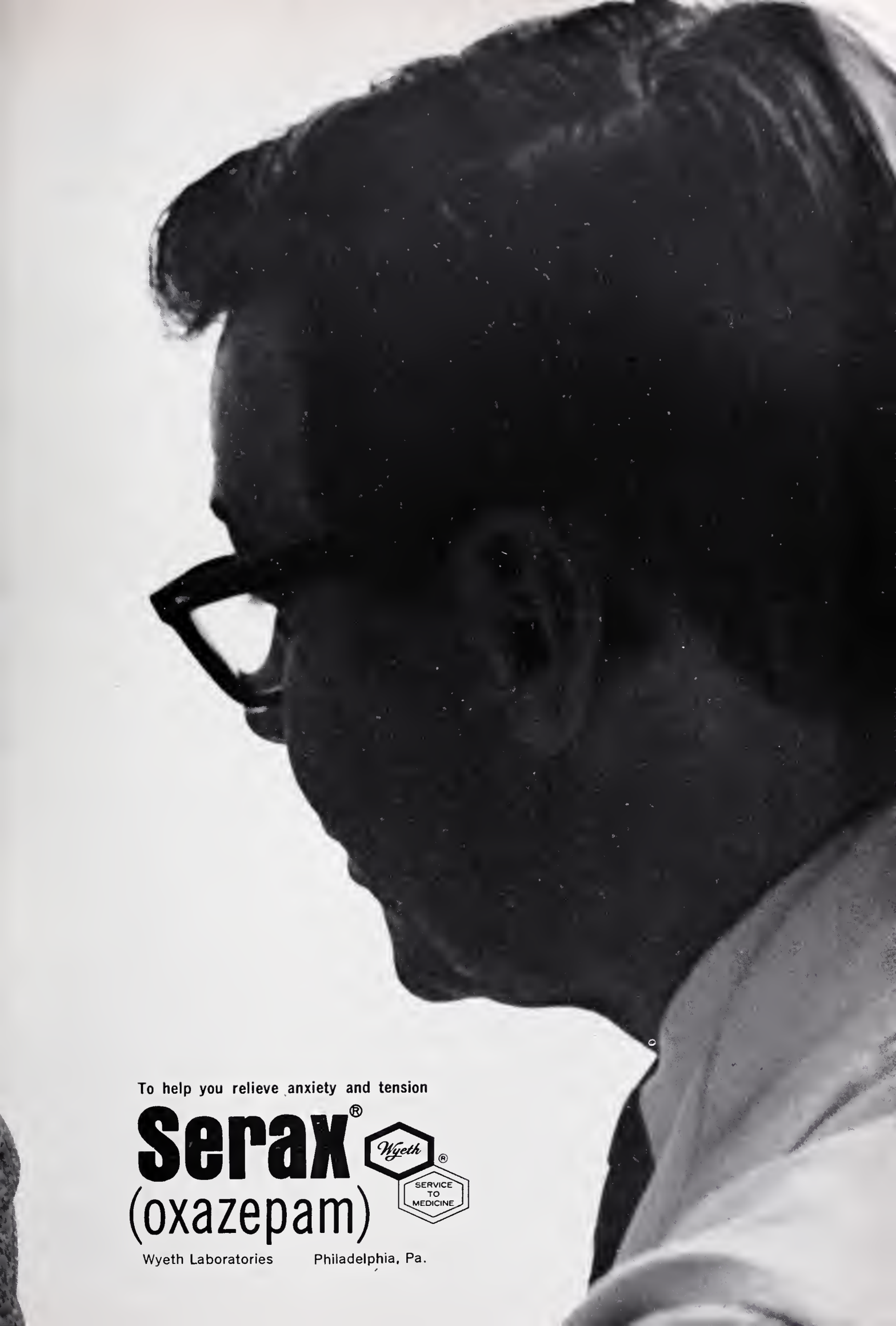
**Side Effects:** Therapy-interrupting side effects are rare. Transient mild drowsiness is common initially; if persistent, reduce dosage. Dizziness, vertigo and headache have also occurred infrequently; syncope, rarely. Mild paradoxical reactions (excitement, stimulation of affect) are reported in psychiatric patients. Minor diffuse rashes (morbilliform, urticarial and maculopapular) are rare. Nausea, lethargy, edema, slurred speech, tremor and altered libido are rare and generally controllable by dosage reduction. Although rare, leucopenia and hepatic dysfunction including jaundice have been reported during therapy. Periodic blood counts and liver function tests are advised. Ataxia, reported rarely, does not appear related to dose or age.

These side reactions, noted with related compounds, are not yet reported: paradoxical excitation with severe rage reactions, hallucinations, menstrual irregularities, change in EEG pattern, blood dyscrasias (including agranulocytosis), blurred vision, diplopia, incontinence, stupor, disorientation, fever and euphoria.

**Availability:** Capsules of 10, 15 and 30 mg. oxazepam.

Photograph posed by professional models.





To help you relieve anxiety and tension

**Serax®**

(oxazepam)

Wyeth®

SERVICE TO MEDICINE

Wyeth Laboratories Philadelphia, Pa.

## *Hawaii Medical Association* *continued from 464*

**ACTION:**

**It was voted that the budget for 1967-68 be presented to the House of Delegates with the recommendation that it be approved.**

**It was voted that the dues for the calendar year 1968 be set at $140.00.**

**It was voted that the registration fee for non-member military physicians be waived for the 111th Annual Meeting.**

**It was voted that the registration fee for professional people, other than MD's, in academic work be waived for the 111th Annual Meeting.**

**UNFINISHED BUSINESS**

*Bureau of Planning and Research:* The Bureau of Planning and Research previously presented a proposal to the Council whereby they asked approval to seek outside funds to pay for the services of an authority trained in analyzing the medical care of communities to study medical care as it exists and is developing in Hawaii. The Council voted to approve the request of the Bureau of Planning and Research.

The Bureau is now asking for approval by the Council to bring one person to Hawaii to meet with the HMA Council and members of eleemosynary disbursement committees and respectfully requests that the Council appropriate funds for this purpose.

**ACTION:**

**It was voted to allocate an amount of money not to exceed $700 for this purpose.** ■

## *County Society Reports* *continued from 444*

Approximately 220 members were present at the March 7 meeting. Two new members, Ralph Byron Berry and Byron Amdur Eliashof, were introduced. "Managing Your Finances through Loans, Investments, and Trusts" was the topic discussed by Bob Martin of Investors Diversified, William Royce of Bishop Trust, and Roger MacArthur from the First National Bank. Dr. George Goto gave a brief summary of pertinent legislation introduced in the State Legislature. Dr. Tomita gave a step-by-step report of the events that led to the discontinuance of government physicians by the Department of Social Services. Dr. Chew Mung Lum reported on the status of negotiations with HMSA. It was voted to reaffirm the HCMS action of the previous meeting to express confidence in the Negotiating Committee and approval of their current position in negotiations with HMSA. Mr. Thorson reported on the Foundation's new contracts.

' ' '

Approximately 204 members attended the April 4 meeting. One new member was introduced, Ann Barbara Ho Yee. Dr. Walter Quisenberry introduced the speaker for the evening, Mr. William Cumler, who talked on "Physical Fitness." The availability of the Physicians' Information Kit was announced. Mr. Thorson reported on the Foundation activities. Dr. Mills commented on the AMA Group Disability Program. Members were asked to accept speaking engagements when called upon by the Speakers Bureau. At the invitation of the Society, Dr. Robert Katsuki, chairman of the HMSA Medical Committee, was present to explain to the membership the proposed changeover to the new concept of "usual and customary" fees.

### Kauai

All members and one guest, Dr. Robert Faus, were present at the April 4 meeting. Corrections in the previous minutes relative to mandatory typhoid and paratyphoid vaccination, and bylaw amendments relating to members' 65th birthdays, were made. A critique of the Workmen's Compensation Bureau Public Hearing was held. A letter was drafted to Senator Inouye relative to drug sales by physicians. All members will be asked to sign the letter. The meeting concluded with a movie on "Intra Uterine Devices."

### Maui

The scientific portion of the February 21 meeting was devoted to a discussion of "Diabetes in Pregnancy" led by Lt. Col. William Scragg from Tripler. Following this Dr. Joseph Andrews briefed the Society on his recent budgetary problems at Kula Sanatorium. It was voted to draft a proposal for the Legislature supporting Dr. Andrews' legitimate position.

' ' '

HMA President and President-elect, Drs. Tomita and Richardson, were present at the March 21 meeting held at the Sheraton Maui Hotel. After a discussion of the public hearing on the Workmen's Compensation Fee Schedule scheduled for Maui, Dr. Iaconetti was placed in charge of preparing for the hearing. Dr. Tomita explained the procedure used at the public hearing held on Oahu. Drs. Tomita and Richardson gave the background information on the events that led up to the subsidy arrangement with the DSS. The current status of HMSA negotiations were also discussed as was the legality and ethics of contract medicine. Mr. Tom Thorson was present to discuss the Foundation Medical Plan and advised that Maui County had the highest percentage of participating physicians. ■

## *Book Reviews* *continued from 443*

presents readable capsule form the essence of the various behavioral sciences and how they contribute to the understanding of human behavior and to psychotherapy.

The scope of the book is tremendous. It covers subjects ranging from genetics, neurophysiology, and cybernetics to psychoanalysis, ecology, and philosophy. Dr. Wolberg calls himself a "reasoned eclectic," and his book reflects an open, objective presentation of the contributions of the various schools engaged in the study of human behavior. He emphasizes, however, that a reasoned eclectic does not approach the enormously complex problem of human behavior with a passive, uncritical, any-approach-is-all-right type of mind, but rather with one which is constructively selective, critical, and synthesizing.

The "reasoned reader" of this book will not only begin examining the foundation of his basic beliefs regarding human behavior and psychotherapy, but will also be stimulated to study more intensively many of the subjects which the author was only able to introduce.

WALTER F. CHAR, M.D.

### ★U.S. Army Medical Department, United States Army in World War II. The Technical Services, the Medical Department: Medical Service in the Mediterranean and Minor Theaters

*By Charles M. Wiltse, Office of the Chief of Military History Department of the Army, 664 pp., $5.00, U. S. Government Printing Office, 1965.*

THIS VOLUME gives an account of organization and operation of medicine under battle and combat-ready conditions by the U. S. forces during World War II. The part played by corpsmen and litter bearers is graphically described, particularly in the areas where the patients were brought down from the Italian Alps in areas too steep for mules to climb.

This war, like most others, required new techniques that were progressively developed as time went on. Considerable education was required to get the line commanders to utilize preventive medicine, measures such as having their troops faithfully take atabrine, to their best advantage.

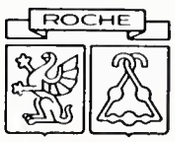
Considerable emphasis was put on the psychological

*continued page 470*

# WHEN ANXIETY IS A SIGNIFICANT COMPONENT OF THE CLINICAL PROFILE

# LIBRIUM®
## (chlordiazepoxide HCl)

**Also available as**
**LIBRITABS[T.M.] (chlordiazepoxide)**
**5-mg, 10-mg, 25-mg tablets**




Before prescribing, please consult complete product information, a summary of which follows:

**Contraindications:** Patients with known hypersensitivity to the drug.

**Warnings:** Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

**Precautions:** In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

**Adverse Reactions:** Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver-function tests advisable during protracted therapy.

**Usual Daily Dosage:** Individualize for maximum beneficial effects. *Oral*—Adults: Mild and moderate anxiety and tension, 5 or 10 mg t.i.d. or q.i.d.; severe states, 20 or 25 mg t.i.d. or q.i.d. Geriatric patients: 5 mg b.i.d. to q.i.d. (See Precautions.)

**Supplied:** Librium® (chlordiazepoxide HCl) Capsules, 5 mg, 10 mg and 25 mg—bottles of 50. Libritabs[T.M.] (chlordiazepoxide) Tablets, 5 mg, 10 mg and 25 mg—bottles of 100. With respect to clinical activity, capsules and tablets are indistinguishable.

**Roche Laboratories** • Division of Hoffmann-La Roche Inc • Nutley, N.J. 07110

boost to all wounded personnel by the knowledge of corpsmen readily available to help them. In other psychological areas, details of therapy of psychiatric casualties close to the front lines are discussed.

An appendix lists detailed operations involving specific units. These will be of considerable interest to physicians 45 and older, as these were the men who were over there.

This volume, like its predecessor, is surprisingly interesting; something rather unexpected in what is supposed to be a historical review. The author is to be congratulated on having produced such a readable volume.

RAYMOND M. DEHAY, M.D.

## An Atlas of Orthopedic Surgery

*By Lewis Cozen, M.D., F.A.C.S., F.I.C.S., 732 pp., $15.00, Lea & Febiger, 1966.*

THIS REVIEWER finds it difficult to write a critique of *An Atlas of Orthopedic Surgery* by Louis Cozen because of a very specific bias towards such atlases. All too often surgeons become technicians and such a book encourages the development of technicians rather than thinking surgeons. A totally untrained intern may quickly brush up on the technique of a specific procedure. With the important points of the anatomy being brought freshly to mind, without any idea of why he is operating nor the ability to modify his approach should an unexpected process be found, he proudly goes forth to do battle with evil.

The book itself is relatively complete. The author methodically goes through the musculo-skeletal system describing each anatomical part in order and most of the common procedures as they relate to the part with little consideration of their merit. There is usually a single sentence regarding indications for the procedure and from six to twenty or so sentences describing in succinct terms the technique. Frequently there is a short paragraph or two of discussion which usually pertains to the technical problems. Postoperative care is rarely noted other than the initial method of immobilization or dressing. It is consequently a shame that the author spent such a great deal of time and effort on the book and that his illustrations are so simply and masterfully done. All this work was extremely time-consuming for a book of such limited usefulness.

In addition, there is a good bibliography of important references as they pertain to the subject matter. A section on skin incisions is interestingly laid out and by and large avoids most of the pitfalls so frequently observed in clinical practice. However in this section such a simple incision as the approach to the tibia shows the malignant pretibial approach. No effort is made to demonstrate that this incision should not lie over the subcutaneous surface. The index itself is adequate.

With all its merit there is little likelihood that anyone but the inexperienced intern or assistant resident will use it. He will be caught thumbing madly through the pages to look for an operation he is scheduled to carry out within minutes. Few orthopedists need look at the book. Other practicing physicians who do look, will find little of true value.

LAWRENCE H. GORDON, M.D.

## ★Controversy in Internal Medicine

*Edited by Franz J. Ingelfinger, M.D., Arnold S. Relman, M.D., and Maxwell Finland, M.D., 679 pp., $14.50, W. B. Saunders Company, 1966.*

THIS EXCELLENT BOOK airs the various aspects of problems seldom discussed in one single volume. The section on 5-FU in the treatment of adenocarcinoma is so significant that it behooves all physicians interested in cancer to read it thoroughly.

Naturally, all topics in medicine are not covered because of limitations of space and time. But this book is well written, well edited, and is filled with information for the internist, surgeon, general practitioner, as well as any student interested in human disease.

Controversy is always stimulating and the expressions of different opinions always beneficial. Because of the interrelatedness of different disciplines, this book is highly recommended not only for the internist, but for the surgeon and for all others interested in the problems well aired in this book. For those who read this book, a better impression and perception of the multiple facets of any problem in medicine will be secured.

This book is highly recommended.

WINFRED Y. LEE, M.D.

## Pulmonary Diseases and Anomalies of Infancy and Childhood

*By Milton I. Levine, M.D., F.A.C.C.P., and Armond V. Mascia, M.D., F.A.C.C.P., 368 pp., $12.00, Hoeber Medical Division, Harper & Row, Publishers, 1966.*

DOCTORS LEVINE AND MASCIA have attempted to fill the need for "a convenient source of information on the wide range of pulmonary diseases" of childhood. They have focused on differential diagnosis in producing "a clinical book" and have thereby only partially fulfilled the stated purpose, since pulmonary physiology and other basics such as segmental anatomy have been completely omitted.

This book is extremely organized (perhaps overly so),

*continued page 472*

**WILLIAMS MORTUARY**

*"CHAPEL OF THE CHIMES"*

**1076 S. Beretania St., Phone 52-587** **Ample Parking Adjoining Mortuary**

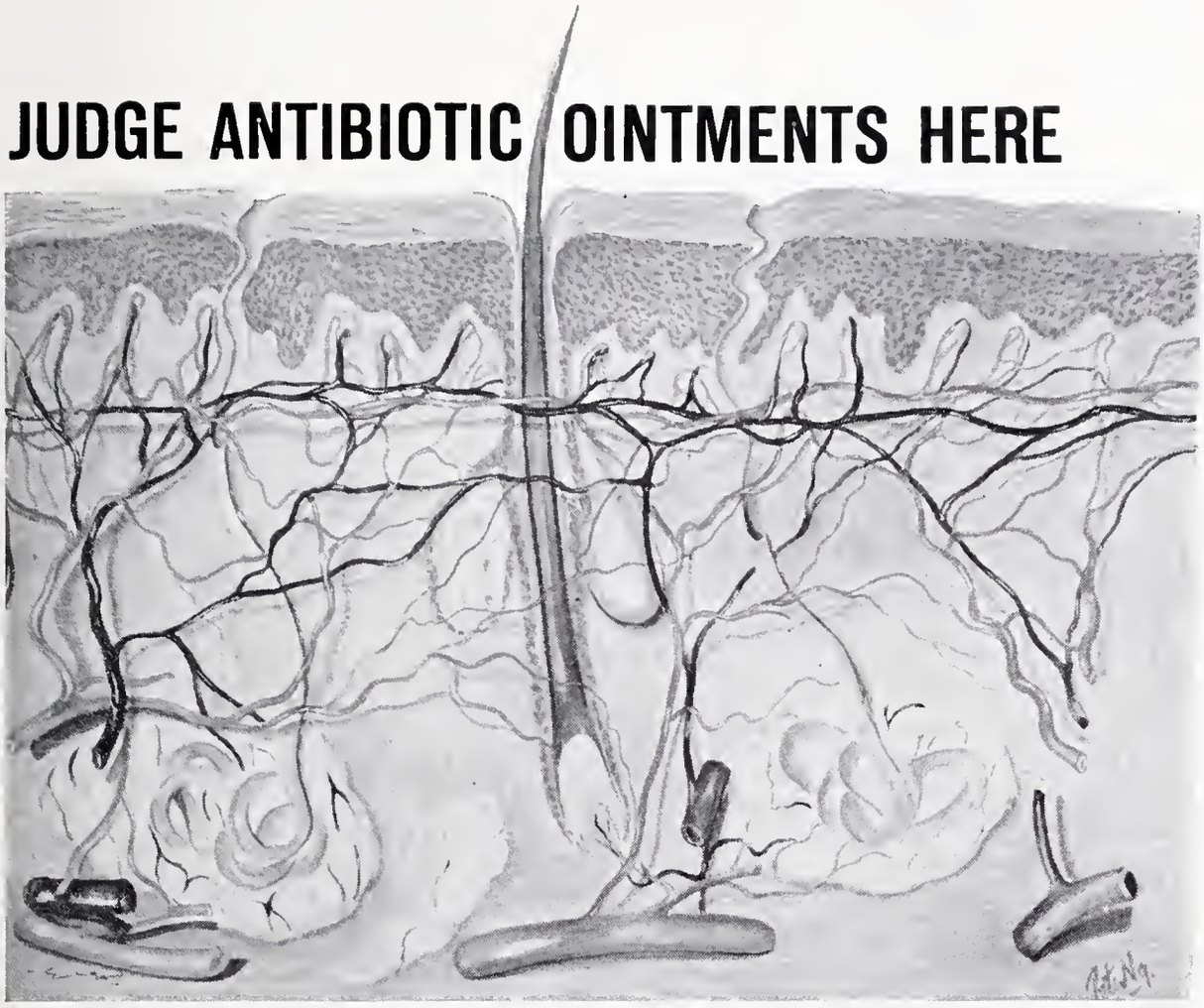
**OVER A CENTURY OF SERVICE**

*"Service measured not by gold but by the Golden Rule"*

***MEMBER***

National Selected Morticians, National Funeral Directors Association,
Order of the Golden Rule, Hawaii Funeral Directors Association

# JUDGE ANTIBIOTIC OINTMENTS HERE



## Results on skin are final proof of any topical antibiotic's effectiveness

**No in vitro test can duplicate a clinical situation on living skin.** 'Neosporin' (polymyxin B—bacitracin—neomycin) Ointment has consistently proven its effectiveness in thousands of cases of bacterial skin infection. The spectra of the three antibiotics overlap in such a way as to provide bactericidal action against most pathogenic bacteria likely to be found topically. Diffusion of the antibiotics from the special petrolatum base is rapid since they are insoluble in the petrolatum, but readily soluble in tissue fluids. The Ointment is bland and nonirritating.

**Caution:** As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

**Contraindications:** This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

**Supplied:** Tubes of 1 oz., ½ oz. with applicator tip, and ⅛ oz. with ophthalmic tip.

Complete literature available on request from Professional Services Dept. PML.

# 'NEOSPORIN'®

**brand**

## POLYMYXIN B-BACITRACIN-NEOMYCIN OINTMENT

**BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.**

with an encyclopedic but very brief coverage of the widest possible range of disorders involving the chest in children. The many x-ray reproductions are unusually clear, well chosen, and clearly labeled, as are the illustrative diagnoses. Chapter bibliographies are most valuable, including classic as well as current references organized by topics. In addition, the index is especially helpful since differential diagnoses are cross referenced.

On the other hand, the writing is telegraphic and dry, making reading for other than quick reference purposes rather tedious. In general, discussions of therapy and of the indications for special investigations are overly brief and grossly inadequate, except in the case of asthma, where the holistic approach is succinctly presented. Tests of pulmonary function, so important in many respiratory problems, are afforded only two brief paragraphs with no real description of the technics or their usage. Furthermore, one might criticize such specific omissions, as of the newer penicillins in staphylococcal pneumonia, or errors such as the inclusion of the dye test for toxoplasmosis under a list of skin tests.

In summary, this book is useful as a reference guide to differential diagnosis, but it falls far short as a source book. It is to be hoped that any future editions will be expanded to truly fill our real need for a textbook in this rapidly developing pediatric subspecialty.

JOSEPH OREN, M.D.

## Current Diagnosis

*Edited by Howard F. Conn, M.D., Robert J. Clohecy, M.D., and Rex B. Conn, Jr., M.D., 843 pp., $19.00, W. B. Saunders Company, 1966.*

THIS IS a rather successful effort designed to provide the physician with a convenient and authoritative source of information pertinent to his patient's illness. It is patterned after the author's other work, *Current Therapy*.




The text is complete, offering succinctly written chapters about the total spectrum of diseases. Each chapter is concerned with a disease or a group of diseases which fall easily under one category. Each is written by an authority in that area and this has tended to increase the accuracy of the text, although it has also resulted in considerable variation in style and clarity. The chapters include a concise definition of the disease entity being dealt with, as well as the signs, symptoms, complications, laboratory and x-ray findings, and other procedures of value in identifying the disease.

Because of the wide scope and the intended simplicity of presentation, some rather complicated problems are presented superficially. In spite of this (or because of this), I feel the text serves a definite and useful purpose especially to the busy practitioner who has been inundated by the constant flood of new information concerning all phases of medicine.

M. G. BOTTICELLI, M.D.

## The Heart and Circulation in the Newborn and Infant

*Presented by The Chicago Heart Association, Edited by Donald E. Sassels, M.D., 426 pp., $9.50, Grune & Stratton, 1966.*

IN THE PAST, most texts on congenital heart diseases (except for surgical texts) have emphasized the diagnosis of the specific lesions with little attention to treatment.

In the past 15 years, great strides have been made in the surgical treatment of congenital heart disease, earlier, in the older child, and more recently, in infants and newborns.

This collection of papers by physicians eminent in the field of cardiovascular disease reflects this newer trend of emphasis on surgical treatment in early life.

The first half of the book is an excellent presentation of cardiovascular physiology in the fetus and newborn, while the second half deals with the surgical treatment of those diseases in infancy in which survival cannot occur without surgical intervention.

This is an excellent book for the pediatrician especially interested in neonatology and for the physician who deals with congenital heart disease in his office.

FRANCES F. NAKAMURA, M.D.

## ★Primary Hepatoma

*Edited by Walter J. Burdette, A.B., A.M., Ph.D., M.D., 150 pp., $0.00, University of Utah Press, 1966.*

THIS BOOK is a series of articles written by investigators in the field of hepatic cancer. The chapters are grouped into sections, each of which is given a general heading (for example: Etiologic Considerations). Each chapter ends with a summary followed by a list of references. The final section of the book is a transcript of a discussion among several of the authors. The chapters are well written and succinct. Photographs are pertinent and well reproduced.

The presentation of this material was sponsored by the National Advisory Cancer Council. It was not intended to be a complete and detailed text on hepatomas, but rather an introduction to the present thoughts and investigations in the field. As such it is an enlightening and worthwhile addition to the pathologist's library, and should be of interest to clinicians as well.

ANN B. CATTS, M.D.

## Kidney and Electrolytes: Foundations of Clinical Diagnosis and Physiologic Therapy

*By Norman Deane, M.D., 198 pp., Prentice-Hall, Inc., 1966.*

ELECTROLYTES and electrolyte regulation continue to be sources of confusion and problems in diagnosis and

*continued page 474*



*She simply sits while the party goes on around her, already used to being the girl who is left out. She tries to lose weight—but her emotions won't let her. She becomes irritable and depressed when she doesn't eat, and anxious when she considers her future. So each time she gives up.*

*"What can I do?" she asks when she visits your office. "How can I ever stay on a diet and lose weight?"*

**A PARTICULAR COMBINATION OF ACTIONS**

# Ambar #2 Extentabs®

methamphetamine hydrochloride 15 mg., phenobarbital 64.8 mg. (1 gr.)
(Warning: may be habit forming).

**FOR THE NEEDS OF THE DIETING WOMAN**

A. H. Robins Co., Inc.
Richmond, Va. 23220

A·H·ROBINS

Ambar is formulated to specifically meet both the physical and emotional needs of the woman who is trying to lose weight. *Methamphetamine hydrochloride* has a powerful suppressant effect on the appetite and also provides a gentle psychic lift to improve mood and encourage activity. The *phenobarbital* component, through its classic calming action, helps control irritability and anxiety, and helps counteract excessive CNS stimulation.

Also available: Ambar #1 Extentabs®—methamphetamine hydrochloride 10 mg., phenobarbital 64.8 mg. (1 gr.) (Warning: may be habit forming).

BRIEF SUMMARY / *Indications:* Ambar suppresses appetite and helps offset emotional reactions to dieting. *Side Effects:* Nervousness or excitement occasionally noted, but usually infrequent at recommended dosages. Slight drowsiness has been reported rarely. *Precautions:* Administer with caution in the presence of cardiovascular disease or hypertension. *Contraindications:* Hypersensitivity to barbiturates or sympathomimetics; patients with advanced renal or hepatic disease. See package insert for further details.

treatment. The most rational approach to diagnosis and treatment is almost always best accomplished by understanding the pathophysiology of a clinical situation. To this end, Dr. Deane presents a text on the kidney and electrolytes which is highly recommended.

Some of the major topics discussed are: basic physiology in relation to electrolytes as influenced by the kidney, heart and lungs, hyponatremia and dehydration, acidosis, hypokalemia and alkalosis, edema, renal failure, calcium and magnesium disorders, and clinical principles of parenteral fluid therapy. The many simple figures aid in understanding the text, which is full of the "pearls" so necessary for an understanding of the complex interrelationships of electrolyte abnormalities.

Although this text is highly recommended, it is not a simple text which gives all the answers on first reading. As stated by Dr. Deane in the preface, "reading, clinical application, rereading, and clinical reapplication are required." It is in this light that this text will best serve the clinician in unraveling the mysteries of electrolytes and their regulation in health and disease.

WINFRED Y. LEE, M.D.

### ★Electrocardiography in Infants and Children

*Sponsored by the American College of Chest Physicians. Editors Donald E. Cassels, M.D., and Robert F. Ziegler, M.D., 366 pp., $16.75, Grune & Stratton, 1966.*

UNDERSTANDING ELECTROCARDIOGRAMS of infants and children has been difficult, due to the wide variation of normal patterns and due also to the presence of abnormal patterns in congenital heart diseases. This text is, in reality, a well-organized series of lectures on pediatric electrocardiography. One need not be a cardiologist to understand this text, for it has been prepared primarily for physicians who are seeing children in their medical practice. Each subject is well illustrated by electrocardiographic tracings supplemented adequately with diagrams, x-rays, angiocardiograms, vectorcardiograms, and pulse pressure curves. Each subject is handled concisely, and the bibliography is selective and current. The contributors are highly regarded in cardiology and add considerable status to the text.

COOLIDGE S. WAKAI, M.D.

### Spontaneous Regression of Cancer

*By Tilden C. Everson, M.D., Ph.D., F.A.C.S., and Warren H. Cole, M.D., F.A.C.S. (Eng., Hon.), F.R.C.S., 560 pp., $20.00, W. B. Saunders Company, 1966.*

A CAREFUL ANALYSIS of the world literature on cases of spontaneous regression of cancer forms the basis of this interesting monograph. Of 176 cases accepted as fulfilling the necessary criteria, over one-half occurred in hypernephroma, neuroblastoma, malignant melanoma, and choriocarcinoma. Despite the increasing incidence of published reports on this unusual phenomenon, no specific etiological factor has been delineated with certainty, although many theories have been postulated. Besides the case reports, an extensive bibliography is provided for the interested oncologist. A good reference text for any medical library.

EDWARD JIM, M.D.

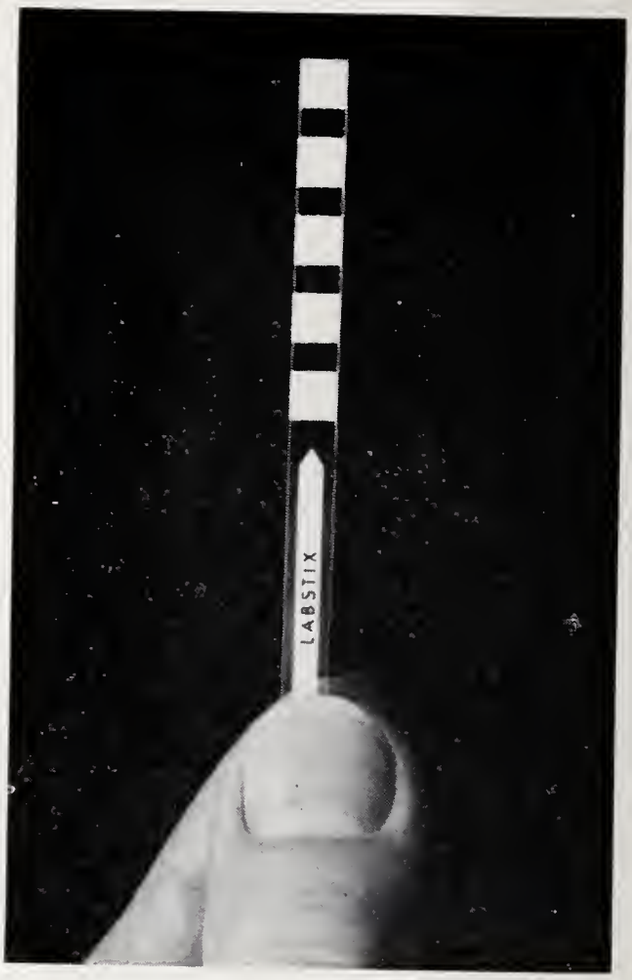
### ★Current Psychiatric Therapies, Vol. 6

*Edited by Jules H. Masserman, M.D., 382 pp., $13.50, Grune & Stratton, 1966.*

THIS VOLUME continues to maintain the high quality of material presented in the five previous volumes. It not only covers the latest developments in many types of psychiatric therapies, but without exception presents each subject clearly and concisely, yet fully enough so that the reader can start to incorporate it into his own practice.

It can help to broaden the viewpoint and practice of psychiatrists, and should be considered as a "must" in their libraries.

YAN TIM WONG, M.D.




**Take five...**

LABSTIX® provides 5 important urinary findings*—on a single reagent strip! That's *more* information than you can get from any other single reagent strip. You know the results in just 30 seconds—while the patient is still in your office—and readings are reliable and reproducible. LABSTIX is easy to handle, too. Never goes limp, even when wet, because it's made with clear, firm plastic. And results with LABSTIX are easy to read—color contrast between the test areas and the transparent plastic is clearly defined. An unexpected "positive" from testing with LABSTIX may help in detecting hidden pathology before marked symptoms are manifest.

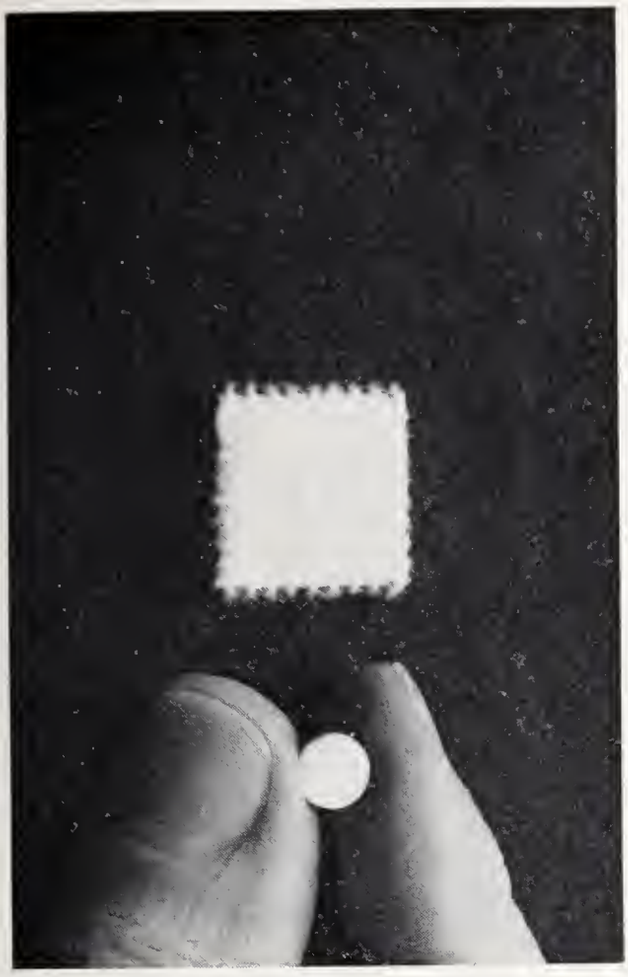
*Blood; ketones; glucose; protein, and pH.

AMES COMPANY
Division Miles Laboratories, Inc.
Elkhart, Indiana 46514

Ames

Note: *AMERICAN HOSPITAL FORMULARY SERVICE CATEGORY NUMBER 36:88*

40167



# ...Plus one

You can extend your testing scope by including ICTOTEST® Reagent Tablets, the 30-second determination for bilirubinuria—which can be an early sign of obstruction of the common bile duct, infectious hepatitis, or other liver disease. This test is also useful for detecting liver damage from carbon tetrachloride and other halogenated hydrocarbons used as industrial and household solvents. Positive findings with the urine-testing team of LABSTIX and ICTOTEST can represent significant guides to patient management in many clinical situations. "Negatives" may help rule out suspected abnormalities over a broad clinical range and are important for the patient's record.

AMES COMPANY
Division Miles Laboratories, Inc.
Elkhart, Indiana 46514

Ames

Note: *AMERICAN HOSPITAL FORMULARY SERVICE CATEGORY NUMBER 36:88*

40167

## Also Received

### Questions and Answers in Orthopaedics: For Students, Interns, Residents, and Board Aspirants

*By Floyd G. Goodman, B.S., M.D., George R. Schoedinger, III, B.S., M.D., 244 pp., $9.85, C. V. Mosby Co., 1966.*

AN EXCELLENT review text for orthopedic board candidates.

### Differential Diagnosis of Cardiovascular Disease by X-ray (With an atlas of 98 plates)

*By Phillip H. Meyers, M.D., Manuel Roy, Jr., M.D., and Charles M. Nice, Jr., M.D., Ph.D., 187 pp., $10.50, Hoeber Medical Division, Harper & Row, Publishers, Inc., 1966.*

A GOOD GUIDE for the practicing physician in making a diagnosis of a cardiovascular disorder by an x-ray. There is an atlas of 98 x-ray plates.

### Molecular Architecture in Cell Physiology

*Edited by Teru Hayashi and Andrew G. Szent-Gyorgyi, 252 pp., $7.50, Prentice-Hall, Inc., $1966.*

AS THE TITLE indicates, a very basic subject for those with very special interests.

### ★Anatomy of the Human Body, 28th Ed.

*By Henry Gray, F.R.S. Edited by Charles Mayo Goss, A.B., M.D., 1448 pp., $22.50, Lea & Febiger, 1966.*

A COMPLETELY REVISED edition of this magnificent anatomical classic.

### ★The Yellow Emperor's Classic of Internal Medicine

*By Ilza Veith, 260 pp., $8.00, University of California Press, 1966.*

FOR THOSE INTERESTED in the basis of Chinese medicine, this scholarly but readable text is highly recommended. Beautifully illustrated.

### Scleroderma

*By Marin A. Snackner, M.D., 174 pp., $13.75, Grune N Stratton, 1966.*

AN EXTREMELY well illustrated review of this uncommon entity. This text appears to be an excellent reference source for all the manifestations of scleroderma.

### Science and Psychoanalysis Decennial Volume, Sexuality of Women, Vol. 10

*Edited by Jules H. Masserman, M.D., 168 pp., $7.75, Grune & Stratton, 1966.*

A STIMULATING subject psychoanalytically reviewed.

### Osler's Textbook Revisited: Reprint of Selected Sections with Commentaries

*Edited by A. McGehee Harvey and Victor A. McKusick, Johns Hopkins University School of Medicine, 361 pp., $6.75, Appleton-Century-Crofts, 1967.*

A PAPERBACK EDITION with selected articles from this landmark in medical literature. Each section is prefaced by an authoritative commentary. This edition is highly recommended for the practicing clinician of today and particularly the internist.

### Treatment of Pericardial Diseases

*Guest Editor Felix M. Cortes, M.D., $16.00 per year, Hoeber Medical Division, Harper & Row, Publishers, Inc.*

ANOTHER PRACTICAL discussion of therapeutic considerations in these two disease entities.

*continued page 480*

# Against these three major pathogens…



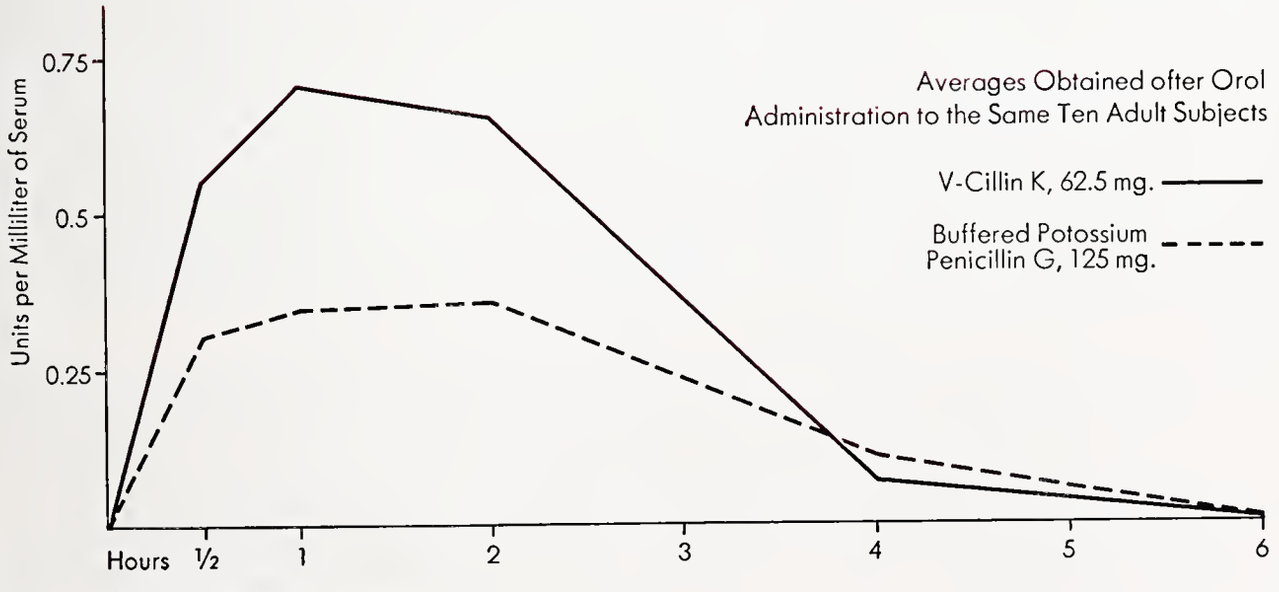
# V-Cillin K® provides dependable oral antibacterial activity

## because it combines a high degree of in-vitro activity...

| Antibiotic | Stoph. Aureus (Penicillin-Sensitive) MIC (mcg./ml.) Median | Range | Streptococcus, Group A MIC (mcg./ml.) Median | Range | Diplococcus Pneumonioe MIC (mcg./ml.) Median | Range |
|---|---|---|---|---|---|---|
| Penicillin V | 0.02 | 0.02-0.04 | 0.02 | 0.003-0.4 | 0.01 | 0.005-0.2 |
| Penicillin G | 0.02 | 0.005-1.6 | 0.005 | 0.002-0.2 | 0.02 | 0.01-0.1 |
| Methicillin | 1.6 | 0.4-6.3 | 0.2 | 0.1-0.4 | 0.2 | 0.1-1.6 |
| Oxocillin | 0.4 | 0.1-3.1 | 0.04 | 0.02-0.4 | 0.1 | 0.04-0.8 |
| Cloxocillin | 0.2 | 0.2-0.8 | 0.1 | 0.1-0.8 | — | — |
| Nofcillin | 0.4 | 0.2-0.8 | 0.04 | 0.02-0.1 | 0.02 | 0.02-0.2 |
| Ampicillin | 0.2 | 0.1-0.8 | 0.02 | 0.01-0.04 | 0.02 | 0.01-0.04 |

Adapted from Klein, J. O., and Finland, M.: New England J. Med.,269:1019, 1963.

## with high blood levels, even in the presence of food




Adapted from Griffith, R. S., and Black, H. R.: Current Ther. Res., 6 253, 1964.

**V-Cillin K®** Lilly 700636

**Potassium Phenoxymethyl Penicillin**

*(See next page for prescribing information.)*

# New 500 mg. tablets...a more convenient way to give high doses




**Description:** V-Cillin K is the potassium salt of V-Cillin® (phenoxymethyl penicillin, Lilly). This chemically improved form combines acid stability with immediate solubility and rapid absorption. Higher serum levels are obtained more rapidly with this penicillin than with equal oral doses of penicillin G. The higher serum levels and acid stability of V-Cillin K make it a more dependable penicillin for oral use.

V-Cillin K, Pediatric, is an oral solution of clinically proved V-Cillin K in teaspoon dosage form. When mixed as directed, each 5 cc. (approximately one teaspoonful) will contain 125 mg. (200,000 units) phenoxymethyl penicillin as the potassium salt.

**Indications:** V-Cillin K has been shown to be effective in the treatment of streptococcus, pneumococcus, and gonococcus infections as well as infections caused by sensitive strains of staphylococci. It may be used for the prophylaxis of streptococcus infections in patients with a history of rheumatic fever and for the prevention of bacterial endocarditis after tonsillectomy and tooth extraction in those patients with a history of rheumatic fever or congenital heart disease.

**Contraindication:** V-Cillin K should not be administered to a patient with a history of penicillin hypersensitivity.

**Warnings:** In rare instances, the use of penicillin may cause acute anaphylaxis which may prove fatal unless promptly controlled. This type of reaction appears more frequently in patients with a history of sensitivity reactions to penicillin and in those with bronchial asthma or other allergies. Resuscitative drugs should be readily available for emergency administration. These include epinephrine and pressor drugs (as well as oxygen for inhalation) for relief of immediate allergic manifestations and antihistamines and corticosteroids for delayed effects.

**Precautions:** V-Cillin K should be used cautiously, if at all, in a patient with a strongly positive history of allergy.

In prolonged therapy with penicillin, and particularly with high parenteral dosage schedules, frequent evaluation of the renal and hematopoietic systems is recommended.

In suspected staphylococcus infections, proper laboratory studies (including sensitivity tests) should be performed.

The use of penicillin may be associated with the overgrowth of penicillin-insensitive organisms. In such cases, its administration should be discontinued, and appropriate measures should be taken.

**Adverse Reactions:** Although serious allergic reactions are much less common with administration of oral penicillin than with intramuscular forms, manifestations of penicillin allergy may occur.

Penicillin is a substance of low toxicity, but it does possess a significant index of sensitization. The following hypersensitivity reactions associated with the use of penicillin have been reported: skin rashes ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; and reactions resembling serum sickness, including chills, fever, edema, arthralgia, and prostration. Severe and often fatal anaphylaxis has occurred (see Warnings). Hemolytic anemia, leukopenia, thrombocytopenia, and nephropathy are rarely observed side-effects and are usually associated with high parenteral dosage.

**Administration and Dosage:** For Tablets V-Cillin K and for V-Cillin K, Pediatric, the usual dosage ranges from 125 mg. (200,000 units) three times a day to 500 mg. (800,000 units) every four hours. For infants, the daily dosage may be 50 mg. per Kg. of body weight divided into three doses.

Beta-hemolytic streptococcus infections without associated bacteremia may be treated with 200,000 to 400,0000 units three times a day. Therapy should be continued for a minimum of ten days to prevent development of rheumatic fever and/or other serious complications. Dosage for routine streptococcus prophylaxis in patients with a history of rheumatic fever or congenital heart disease may be 200,000 units once or twice daily. When such patients undergo tonsillectomy, tooth extraction, or other minor surgery, the prophylactic dose should be 500,000 units every six hours given two days prior to surgery and for two days postoperatively. If oral medication is not feasible on the day of surgery, parenteral therapy should be considered. Mild to moderately severe pneumococcus pneumonia has been treated effectively with 250 mg. every six hours.

In staphylococcus infections, 400,000 units or more should be given every six to eight hours in conjunction with indicated surgical procedures.

For gonorrhea in males, 500 mg. (800,000 units) every four hours for three doses may be employed; in females, 500 mg. every four hours for six doses are recommended. Patients with a suspected lesion of syphilis should have a dark-field examination before receiving penicillin and monthly serologic tests for a minimum of three months.

**How Supplied:** Tablets V-Cillin K, U.S.P., 125 mg. (200,000 units), in bottles of 50 and 100; and 250 mg. (400,0000 units) and 500 mg. (800,000 units), in bottles of 24 and 100.

V-Cillin K, Pediatric, for Oral Solution, 125 mg. (200,0000 units) per 5 cc. of solution, in 40, 80, and 150-cc.-size packages. [011867]

*Additional information available to physicians upon request. Eli Lilly and Company, Indianapolis, Indiana 46206.*

Lilly

700636




# Phenaphen® with Codeine

the only leading compound analgesic that calms instead of caffeinates

*Each capsule contains:*

Phenobarbital (¼ gr.) ..... 16.2 mg.
*(Warning: may be habit forming)*
Aspirin (2½ gr.) .....162.0 mg.
Phenacetin (3 gr.) .....194.0 mg.
Hyoscyamine sulfate .....0.031 mg.
Codeine phosphate.....¼ gr. (No. 2), ½ gr. (No. 3), 1 gr. (No. 4)
*(Warning: may be habit forming)*

*Contraindications:* Hypersensitivity to any ingredient.

*Precautions:* As with all phenacetin-containing products, avoid excessive or prolonged use.

*Side Effects:* Side effects are uncommon—nausea, constipation, and drowsiness have been reported.

A-H-ROBINS

A. H. ROBINS CO., INC., Richmond, Va. 23220

### Mental Health in a Changing Community

*Edited by Reed Brockbank, M.D., and Dorothy Westby-Gibson, Ed.D., 163 pp., $6.50, Grune & Stratton, 1966.*

A MUTIDISCIPLINED APPROACH to mental health in our changing society.

### One World of Science: Personal Visits to Men of Research in Many Lands

*By Warren Andrew, Ph.D., M.D., 271 pp., $8.75, Charles C. Thomas, 1966.*

AN INTERESTING NIGHT's reading of Dr. Andrew's visits with some of the most prominent physicians in the world today.

### Proceedings, Western Hemisphere Nutrition Congress

*Organized by the Council on Foods and Nutrition, American Medical Association, November 8-11, 1965, Chicago, Illinois, 255 pp., $5.00.*

NUTRITION AND HEALTH, in its broadest sense, were discussed at this Congress in 1965.

### Progress in Clinical Psychology, Vol. 7

*Edited by Lawrence Edwin Abt, Ph.D., and Bernard F. Riess, Ph.D., 309 pp., $11.75, 1966.*

ANOTHER VOLUME in the progress of clinical psychology.

### Mental Health with Limited Resources

*Edited by Hans R. Huessy, M.D., 124 pp., $5.50, Grune & Stratton, 1966.*

THE PROBLEMS of providing an effective mental health program to the poorer nonurban communities as confronted and approached by these Vermont workers is presented.

WHEN YOU HAVE
A CALL TO MAKE
...CALL HAWAIIAN AIRLINES
FOR CONVENIENT JET FLIGHTS
TO ALL ISLANDS
WHETHER FOR
BUSINESS OR PLEASURE

FOR RESERVATIONS CALL:

| HONOLULU | KAHULUI | LANAI |
|---|---|---|
| 817-611 | 75-011 | 3-222 |
| HANA | KAMUELA | LIHUE |
| 442-483 | 858-505 | 2-751 |
| HILO | KONA | MOLOKAI |
| 50-811 | 256-465 | 37-475 |

HAWAIIAN AIRLINES
Holder of the World's Safety Record

### ★Current Medical Terminology, 3rd Ed.

*Edited by Burgess L. Gordon, M.D., 969 pp., $4.00, American Medical Association, 1966.*

THIS THIRD edition of a timely reference source of medical terms is also useful as a source of concise medical information about each disease.

### Hospital Policy Decisions: Process and Action

*By Arthur B. Moss, Wayne G. Broehl, Jr., Robert H. Guset, and John W. Hennessey, Jr., 332 pp., $8.50, G. P. Putnam's Sons, 1966.*

THIS CLEARLY WRITTEN text on hospital administration appears to be of value for both administrators and doctors concerned with policies and goals of good hospital care.

### Ciba Foundation Study Group No. 23 Egg Implantation

*In honour of Professor R. Courrier, edited by G. E. W. Wolstenholme, O.B.E., M.A., F.R.C.P., F.I. Biol., 122 pp., $3.50, Little, Brown and Company, 1966.*

FOR THOSE INTERESTED in this very basic process in reproductive physiology, this text is highly recommended.

### Basic Human Anatomy

*By Helen L. Dawson, Ph.D., 332 pp., $8.95, Apple-Century-Crofts, 1966.*

AN ABBREVIATED but comprehensive anatomical text with simplified diagrams which should prove of value to the student and for reviews.

### Ciba Foundation Study Group No. 24 Histones: Their Role in the Transfer of Genetic Information

*In honour of Academician W. A. Engelhardt, edited by A. V. S. de Reuck, M.Sc. D.I.C., A.R.C.S., 115 pp., $3.50, Little, Brown and Company, 1966.*

THIS TEXT should be of great interest to the geneticist interested in basic research.

### Ciba Foundation Symposium Touch, Heat and Pain

*Edited by A. V. S. de Reuck, M.Sc. D.I.C., A.R.C.S., 389 pp., $14.00, Little, Brown and Company, 1966.*

THE USUAL TECHNICAL and comprehensive symposium concerning the basic essence of perception of these sensory stimuli.

### Ciba Foundation Symposium The Thymus: Experimental and Clinical Studies

*In honour of Sir Macfarlane Burnet O.M., edited by G. E. W. Wolstenholme, O.B.E., M.A., F.R.C.P., F.I. Biol., 538 pp., $15.00, Little, Brown and Company, 1966.*

MODERN CONCEPTS of the role of the thymus are comprehensively discussed.

### High-Altitude Diseases: Mechanism and Management

*By Carlos M. Monge, M.D., Sc.D., Chicago (Hon.), and Carlos C. Monge, M.D., 97 pp., $5.75, Charles C. Thomas, 1966.*

THESE CLIMATIC DISORDERS are comprehensively discussed.

### Cardiovascular Roentgenology: A Validated Program

*By Charles M. Nice, Jr., M.D., Ph.D., 260 pp., $9.35, Hoeber Medical Division, 1967.*

AN EXCELLENT PROGRAMMED course in paperback form which however is rather expensive. It is well worth the trip to the library for a few night's study at home.

*continued page 485*

# WE'RE READY FOR YOUR CALL

Our job is to have what you want . . . before you ask for it. To plan ahead so that when you call, we've got whatever you want.

And when you do call . . . it's our responsibility to deliver fast. No shortage. No delay. No excuses.

That's our job. To plan ahead . . . then deliver fast. It's a job we're proud to have and plan to keep.



Charles Malang MANAGER
Johnny Kawafuchi Sales Manager
Kenny Hills Salesman—Oahu
Frankie Fernandez Salesman—Oahu
Hideo Kawabata Salesman—Oahu
Bill Lindsey Salesman—Oahu
Masao Miyataki Salesman—Oahu

George Pereira Buyer
Christine Oga Inside Sales —Oahu
Edna Sato Inside Sales —Oahu
Doris Uyeda Inside Sales —Oahu
Elizabeth Azevedo Inside Sales —Oahu
Dorothy Sakabe Inside Sales —Oahu
Eileen Brenessel Secretary

Donald Hangai Warehouseman
Hans Yoshino Warehouseman
Shiro Sodetani Warehouseman
Tokio Hikida Warehouseman
Toshio Yamashita Warehouseman
Masaaki Sasaki General Sales —Hawaii
Yoriyoshi Hara Salesman—Hawaii

**APPLICATORS • DESENEX • DRUG ENVELOPES • ETHER • LYSOL • OINTMENT TINS**

Alcon Laboratories
Arbrook
Ames Co.
Astra Pharm. Products, Inc.
Ayerst Laboratories, Inc.
Bard-Parker
Barnes-Hind Laboratories
Becton-Dickinson & Company
Bristol Laboratories
Brockway Glass Company
Burroughs Wellcome & Co.
CIBA Pharmaceutical Prod., Inc.
Conal Pharmaceutical, Inc.
Davis & Geck Sutures
Dome Chemicals, Inc.
Drug Package Inc.
Eaton Laboratories
Endo Laboratories
Ethicon Inc.
Howe Co.
Hynson, Westcott, Dunning
Invenex Pharmaceuticals
Jelco
Johnson & Johnson
Kirkman Pharmaceutical Company
Lederle Laboratories
Mallinkrodt Chemical Works
McNeil Laboratories
Mead-Johnson & Company
Merrell, William S.
Minnesota Mining & Mfg. Co.
Organon, Inc.
Ortho Pharmaceutical Corp.
Owen Laboratories
Pfizer Laboratories
Pitman-Moore Company
Purdue-Fredericks
Ray-O-Vac Company
Ricker Laboratories, Inc.
A. H. Robins Co., Inc.
Roche Laboratories
J. B. Roerig & Company
Sandoz Pharmaceuticals
Sauter Laboratories
Schering Corp.
The Scholl Mfg. Co., Inc.
Searle & Co., G. D.
Smith, Kline & French Lab.
Stanlabs, Inc.
Strasenburgh Lab.
Strong-Cobb-Arner, Inc.
Syntex
Tampax Inc.
Tidi Products
Travenol Labs, Inc.
U. S. Vitamin & Pharmaceutical Corp.
Vestal Laboratories, Inc.
Wallace Laboratories
Wallace-Tiernan
Warner-Chilcott Lab.
Warren-Teed Pharmaceuticals
Westwood Pharmaceuticals
White Labs.
Winthrop Products, Inc.

**Rx BOTTLES • Rx FILES • PILL BOXES • TONGUE BLADES**

***SAME DAY DELIVERIES • SCHEDULED RURAL DELIVERIES***

Phone 585-531 between 7:30 a.m. and 4:30 p.m. weekdays

**AMFAC INC DRUG DEPARTMENT**

# even better together in mild hypertension

# Serpasil®-Esidrix®

## (reserpine and hydrochlorothiazide CIBA) Combination Tablets



Serpasil-Esidrix combines reserpine (the original, and most widely used, rauwolfia alkaloid developed by CIBA) with hydrochlorothiazide (the most widely used oral diuretic, also a product of CIBA research).



## even better blood pressure reduction—because 2 antihypertensive agents of choice often work better together

One drug potentiates the antihypertensive action of the other. Blood pressure is generally controlled with relatively low dosages of each component, often resulting in minimized side effects.

Although each component alone may provide adequate therapy in many cases of mild hypertension, the combination offers advantages which cannot be achieved with single-drug therapy.



## even more patient benefits—because complementary actions of 2 antihypertensive agents extend the range of advantages

Reserpine, in addition to lowering blood pressure, provides central calming action to help relieve anxiety and tension; provides bradycrotic action to slow the rapid heart.

Hydrochlorothiazide, in addition to lowering blood pressure, relieves edema; permits relaxation of salt restriction.

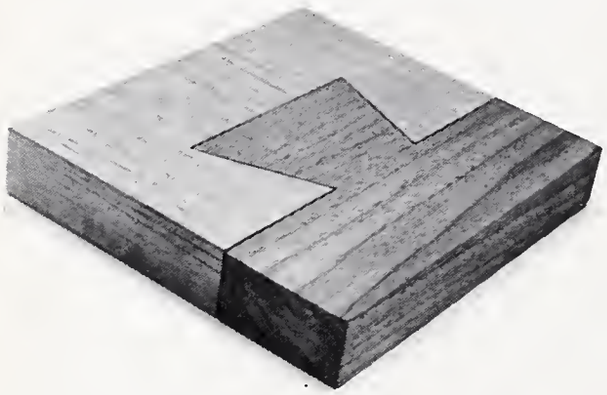
The combination provides medication in one tablet instead of two; one prescription instead of two—encourages patient adherence to the regimen, offers economy.

## for your next patient with mild hypertension

# Rx Serpasil-Esidrix Combination Tablets

Please see following page for prescribing information.

# Serpasil®-Esidrix®
## (reserpine and hydrochlorothiazide CIBA)
# Combination Tablets



INDICATIONS: Mild to moderate hypertension, especially when complicated by anxiety, tachycardia, or edema.

SIDE EFFECTS AND PRECAUTIONARY MEASURES

**Serpasil® (reserpine CIBA)**
Occasional side effects: lassitude, drowsiness, nasal congestion, looseness of stools, increased frequency of defecation. Rare side effects: anorexia, headache, bizarre dreams, nausea, dizziness, skin rash.

Severe mental depression has appeared in a small percentage of patients, primarily in a dosage above 1 mg daily. When the drug is discontinued, depression usually disappears, but hospitalization and shock therapy are sometimes required.

*Caution:* Withdraw reserpine 2 weeks before surgery, if possible. For emergency surgical procedures, give vagal blocking agents parenterally to prevent or reverse hypotension and/or bradycardia.

Because reserpine may increase gastric secretion of hydrochloric acid, use cautiously in patients with peptic ulcer.

Use cautiously with digitalis, quinidine, or guanethidine. Not recommended for aortic insufficiency.

**Esidrix® (hydrochlorothiazide CIBA)**
*Contraindictions:* Oliguria, renal shutdown, progressive hepatic disease, and allergy to thiazides.

*Warnings:* Stenosis, hemorrhage, and ulceration of the small bowel have occurred with coated potassium tablets. Discontinue such medication when used with Esidrix if gastrointestinal disturbances arise.

Pay special attention to electrolyte balance of patients with severe renal or hepatic insufficiency. In patients with cirrhosis and ascites, watch for symptoms of impending hepatic coma. Thiazides may decrease glucose tolerance; use cautiously in diabetics. Hyperuricemia may occur but is readily reversed by a uricosuric agent. Lowering of blood pressure may sometimes result in nitrogen retention, particularly in patients with impaired renal function. Dosage titration is necessary in such patients.

*Precautions:* Watch for signs of fluid or electrolyte imbalance. Further electrolyte depletion may cause hypochloremic alkalosis and hypokalemia. Since the latter may precipitate digitalis intoxication, watch carefully patients who are taking digitalis or its glycosides or those with cardiac arrhythmias. In severe hypokalemia, large oral or intravenous doses of potassium may be required.

A few infants born of mothers who received thiazides during pregnancy have shown bone marrow depression with thrombocytopenia. Hydrochlorothiazide decreases responsiveness to exogenous norepinephrine and increases responsiveness to tubocurarine. Hypotensive episodes under anesthesia have been observed in some patients receiving thiazides.

*Side Effects:* In addition to those above, nausea, anorexia, headache, restlessness, constipation, dizziness, paresthesias, fatigue, increased sweating, cramps in arms and legs, diarrhea, abdominal pain. Rare reactions: purpura with or without thrombocytopenia, skin rash, photosensitivity, urticaria. Sometimes associated with hydrochlorothiazide: leukopenia, agranulocytosis, aplastic anemia, pancreatitis, jaundice, necrotizing vasculitis.

DOSAGE
Average dosage is 2 *Tablets #2* daily. For patients requiring less hydrochlorothiazide, substitute *Tablets #1*. For maintenance, reduce dosage to lowest effective level. When necessary, more potent antihypertensive agents may be added gradually in reduced dosages.

SUPPLIED
*Tablets #2* (light orange), each containing 0.1 mg reserpine and 50 mg hydrochlorothiazide; bottles of 100 and 1000. *Tablets #1* (light orange), each containing 0.1 mg reserpine and 25 mg hydrochlorothiazide; bottles of 100 and 1000.

*Consult complete literature before prescribing.*

CIBA Pharmaceutical Company, Summit, N. J. **C I B A**

2/3595

*Book Reviews continued from 480*

**Synopsis of Neurology, 2d Ed.**

*By Francis M. Forster, B.S., M.D., 218 pp., $7.50, C. V. Mosby Co., 1966.*

A CONCISE TEXT which is recommended for non-neurologists who desire a good review of neurology.

**Medical Resident's Manual, 2d Ed.**

*By Richard J. Kennedy, M.D., F.A.C.P., William J. Grace, M.D., F.A.C.P., and Frank B. Flood, M.D., F.A.C.P., 340 pp., $5.50, Appleton-Century-Crofts, 1966.*

A CONCISE HANDBOOK written specifically for the house staff.

**Microfabric of Man: A Textbook of Histology**

*By Warren Andrew, Ph.D., M.D., 392 pp., $11.00, Year Book Medical Publishers, Inc., 1966.*

A "MODERN" TEXT of histology which is extremely well illustrated. The newer concepts of cell morphology are discussed and may be useful for the clinician who desires to keep abreast with these recent advances.

**Year Book of Nuclear Medicine, Vol. 1**

*By James L. Quinn, III, 384 pp., $10.00, Year Book Medical Publishers, Inc., 1966.*

A WELCOMED "year book" for those with specific and general interest in nuclear medicine.

**Dynamically Oriented Art Therapy: Its Principles and Practices**

*By Margaret Naumburg, 168 pp., $17.50, Grune & Stratton, 1966.*

ART THERAPY, as a method of symbolic communication, is discussed and illustrated. ■

Your stationery
is a reflection
of you...
be certain
the reflection is good!

*star-bulletin printing company*

SB

*the hallmark of fine printing in honolulu*

OXYGEN AIR-CONDITIONED

24-HOUR SERVICE

Physician's



510-477

AMBULANCE SERVICE, INC.

*Hawaii's Finest*

# Our "Angels"


| | Page |
|---|---|
| Amfac, Inc. | 481 |
| American Tobacco Co. | |
| *Tareyton* | 387 |
| Ames Company, Inc. | |
| *Dextrostix* | 389 |
| *Labstix* | 474, 475 |
| Ayerst Laboratories | |
| *Auralgan* | 488 |
| Bishop Trust Company | 375 |
| Bristol Laboratories | |
| *Polycillin* | 382, 383 |
| *Tetrex-F* | 399 |
| Burroughs Wellcome & Co. (U.S.A.) Inc. | |
| *Neosporin* | 471 |
| Carnation Co. | 391 |
| Ciba Pharmaceutical Co. | |
| *Doriden* | 398 |
| *Serpasil—Esidrix* | 482, 483, 484 |
| Coca-Cola Bottling Co., of Honolulu | 472 |
| Eastman Kodak Company | 376, 377 |
| Geigy Pharmaceuticals | |
| *Preludin* | 380, 381 |
| General Diagnostics | 461 |
| Hawaii Medical Service Association | 463 |
| Hawaiian Airlines | 480 |
| Hynson, Westcott & Dunning | |
| *Lutrexin* | 371 |
| Lilly, Eli, & Co. | |
| *Co-Pyronil* | 400 |
| *Darvon Compound 65* | 369 |
| *Ilosone* | 384, 385, 386 |
| *V-Cillin K* | 476, 477, 478 |
| Loma Linda Foods | |
| *Soyalac* | 373 |
| Medical Industries, Ltd. | 460 |
| Medical Placement Bureau | 464 |

| | Page |
|---|---|
| Merrell, The Wm. S., Co. | |
| *Alertonic* | 392, 393 |
| O'Leary, Lydia, of Hawaii | |
| *Covermark* | 486 |
| Optical Dispensers of Hawaii, Inc. | 464 |
| Parke-Davis & Co. | |
| *Benadryl* | 370 |
| Physicians Ambulance | 485 |
| Pitman-Moore | |
| *Novahistine-LP* | 396, 397 |
| Robins, A. H., Co. | |
| *Ambar #2 Extentabs* | 473 |
| *Dimetapp Extentabs* | 388 |
| *Phenaphen* | 479 |
| Roche Laboratories | |
| *Librium* | 469 |
| Schuman Carriage Co., Ltd. | |
| *Cadillacs* | 462 |
| Security Diamond Co. | |
| *Omega Watches* | 465 |
| Searle, G. D. & Co. | |
| *Lomotil* | 379 |
| Star-Bulletin Printing Co. | 485 |
| Stuart Company, The | |
| *Mylanta* | 390 |
| Syntex Laboratories, Inc. | |
| *Norinyl-1* | 449, 450, 451, 452, 453 |
| *Synalar* | 454, 455, 456, 457 |
| Teeny Tots' Footwear | 459 |
| Williams Mortuary | 470 |
| Winthrop Laboratories | 487 |
| Wyeth Laboratories | |
| *Equanil* | 394, 395 |
| *Serax* | 466, 467 |
| Zale's Jewelry Co. | |
| *Glycine Vacuum Watches* | 378 |





**BLEMISHES?**

COVERMARK conceals all skin discolorations . . . birthmarks, brown & white patches, broken veins, tattoos, burns, scars, on any part of the body. COVERMARK is also unexcelled as an overall makeup . . . will not rub or flake off. Waterproof and Sunproof.

*Lydia O'Leary*

**OF HAWAII**

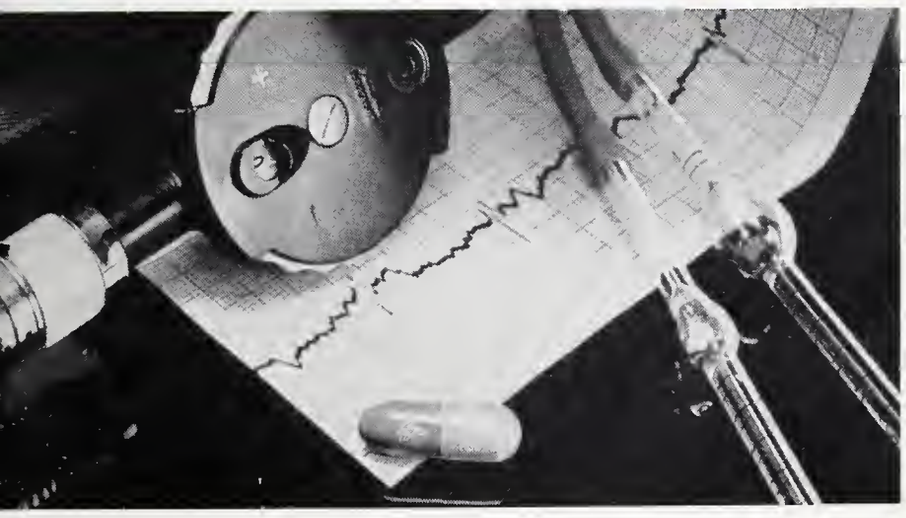
ALA MOANA CENTER—STREET LEVEL

PHONE 993-288

July-August, 1967

# HAWAII MEDICAL JOURNAL

U.C. MEDICAL CENTER LIBRARY
AUG 29 1967
San Francisco



Among the adjuncts to the physician's skill

Darvon® Compound-65

Each Pulvule® contains 65 mg. propoxyphene hydrochloride, 227 mg. aspirin, 162 mg. phenacetin, and 32.4 mg. caffeine.

Additional information available to the medical profession upon request.
ELI LILLY AND COMPANY, INDIANAPOLIS, INDIANA 46206

Lilly

700992

*In this issue*

## Annual Meeting Transactions

Presidential Address

**Generic Equivalence**
Editorial

## Annual Index

*Table of contents, page 494*

VOLUME 26 • NUMBER 6

some allergens are green

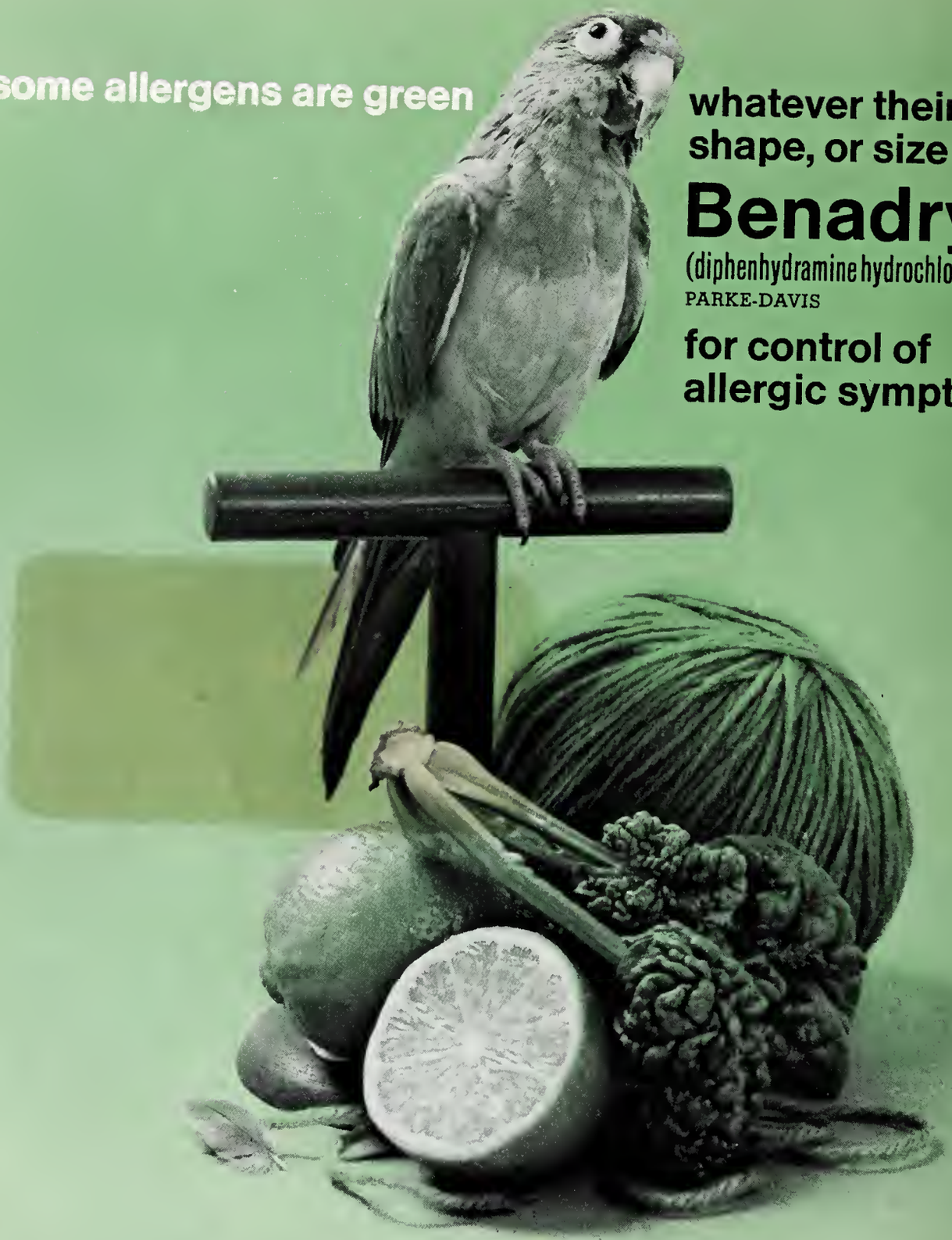
whatever their color, shape, or size...

# Benadryl®

(diphenhydramine hydrochloride)

PARKE-DAVIS

for control of allergic symptoms



Whether the allergen is greenish or garish, unseen or unknown, your patient can get symptomatic relief with BENADRYL—the potent antihistamine with antispasmodic action. *INDICATIONS:* Antihistaminic, antispasmodic, antitussive, and antiemetic therapy. *PRECAUTIONS:* Persons who have become drowsy on this or other antihistamine-containing drugs, or whose tolerance is not known, should not drive vehicles or engage in other activities requiring keen response while using this product. Hypnotics, sedatives, or tranquilizers if used with diphenhydramine hydrochloride should be prescribed with caution because of possible additive effect. Diphenhydramine has an atropine-like action which should be considered when prescribing diphenhydramine hydrochloride. *ADVERSE REACTIONS:* Side effects are generally mild and may affect the nervous, gastrointestinal, and cardiovascular systems. Drowsiness, dizziness, dryness of the mouth, nausea, nervousness, palpitation, blurring of vision, vertigo, headache, muscular aching, thickening of bronchial secretions, restlessness, and insomnia have been reported. Allergic reactions may occur.

BENADRYL is available in Kapseals® of 50 mg. and Capsules of 25 mg.

00867

The pink capsule with the white band is a trademark of Parke, Davis & Company.

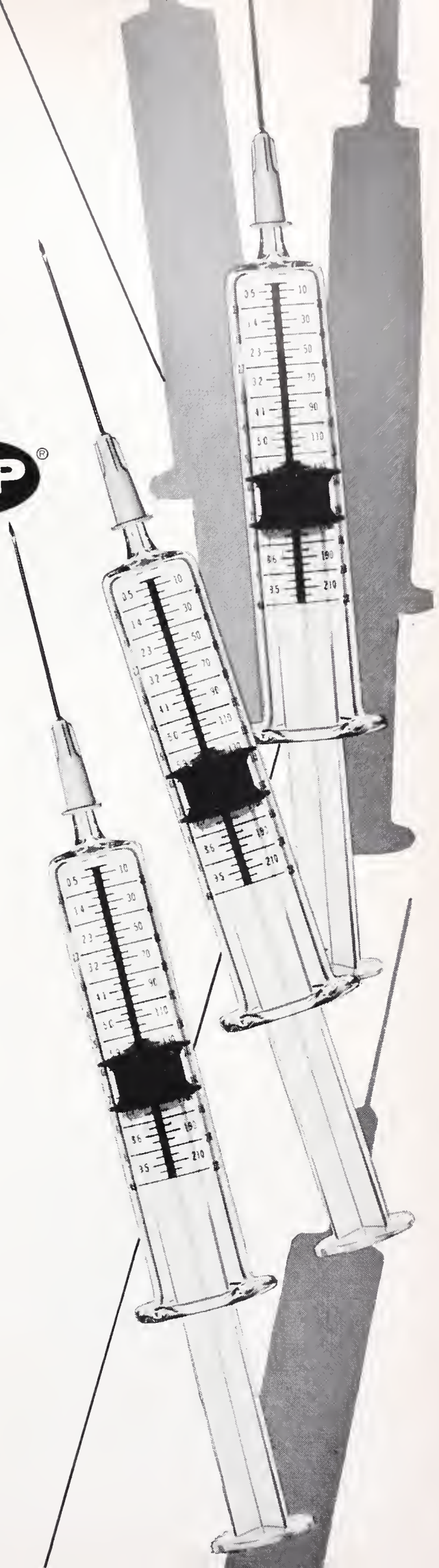
PARKE-DAVIS

# BSP® DISPOSABLE UNIT

## W&D BRAND OF SODIUM SULFOBROMOPHTHALEIN INJECTION, USP

(50 mg. per ml.)

BSP®



ROMSULPHALEIN®
IN A COMPLETE,
STERILE,
DISPOSABLE,
& ECONOMICAL
PATIENT-UNIT.

BSP, one of the more valuable single laboratory procedures for determining hepatic function, is now packaged in a complete individual patient-unit.

Each BSP Disposable Unit contains a sterile syringe with the 5 mg./kg. BSP dosage schedule imprinted on the barrel, a sterile needle, alcohol swab and a 7.5 ml. or 10 ml. size ampule of terminally sterilized Bromsulphalein solution.

This all-inclusive disposable put-up lessens the chance of cross-infection and saves time and labor— the most costly commodities.

**HYNSON, WESTCOTT & DUNNING, INC.**

BALTIMORE, MARYLAND 21201

HW&D (BSP03)

HAWAII MEDICAL JOURNAL

*Published Bi-Monthly by the* HAWAII MEDICAL ASSOCIATION (Incorporated in 1856 under the Monarchy), 510 S. Beretania St., Honolulu, Hawaii 96813 • *Editor,* HARRY L. ARNOLD, JR., M.D. • *News Editor,* HENRY N. YOKOYAMA, M.D. • *Managing Editor,* LEE MCCASLIN

VOLUME 26, NUMBER 6 • JULY-AUGUST, 1967 • $6.00 A YEAR, $1.00 A COPY

# The Hawaii Medical Association

## Officers 1967-1968

President • B. A. RICHARDSON, *Honolulu*
President-Elect • ROBERT M. MIYAMOTO, *Hilo*
Past President • THEODORE T. TOMITA, *Honolulu*
Secretary • R. VARIAN SLOAN, *Honolulu*
Treasurer • HERBERT Y. H. CHINN, *Honolulu*

County Presidents

Hawaii County • ETTA WRIGHT BEST, *Hilo*
Honolulu County • GEORGE H. MILLS, *Honolulu*
Kauai County • BURT O. WADE, *Waimea*
Maui County • BILLIE FERN STROTHER, *Wailuku*

Delegate to A.M.A. • RICHARD D. MOORE, *Honolulu*
Alt. Delegate to A.M.A. • GEORGE H. MILLS, *Honolulu*

## Councillors 1967-1968

Maui • WILLIAM E. IACONETTI
Honolulu • GROVER H. BATTEN
Honolulu • BERNARD W. D. FONG
Honolulu • ANDREW C. IVY, JR.
Hawaii • DAVID WM. JONES
Kauai • SAMUEL R. WALLIS

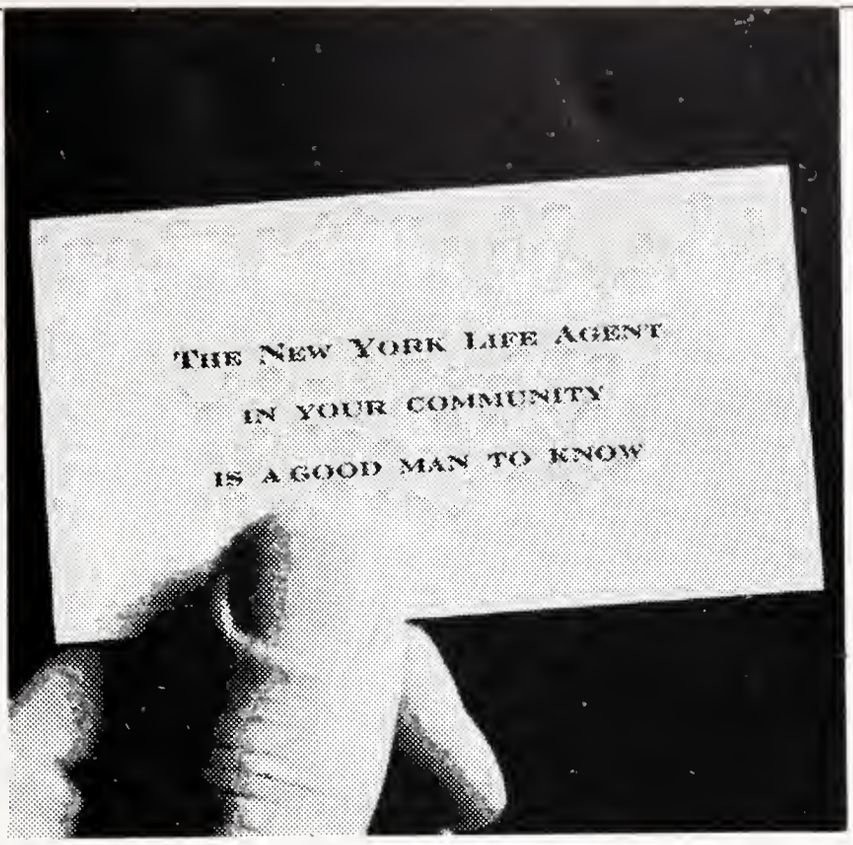
## Officers — County Societies — 1967

| HAWAII | | HONOLULU |
|---|---|---|
| ETTA WRIGHT BEST • | President | • GEORGE H. MILLS |
| FRANCIS F. C. WONG • | Vice President | • KEITH F. O. KUHLMAN |
| REGINALD S. CARVALHO • | Secretary | • HERBERT Y. H. CHINN |
| JAMES K. MATAYOSHI • | Treasurer | • K. S. TOM |

| KAUAI | | MAUI |
|---|---|---|
| BURT O. WADE • | President | • BILLIE FERN STROTHER |
| SAMUEL WALLIS • | Vice President | • SAKAE UEHARA |
| JAMES P. WARNER • | {Secretary} {Treasurer} | • JOHN F. MORRIS |

The JOURNAL may not be held responsible for opinions expressed in papers, discussions, communications, or advertisements. The advertising policy of the HAWAII MEDICAL JOURNAL is governed by the rules of the Council on Drugs of the American Medical Association. The right is reserved to reject material submitted for editorial or advertising columns. All material for publication must be in the hands of the editor on or before the 10th day of the month preceding publication date. Reprints of original articles will be supplied at actual cost, provided request is attached to manuscript or made in sufficient time before publication. A reasonable number of cuts and illustrations accompanying an article will be accepted for printing. The right is reserved to ask the author to bear cost of these when it is found necessary to do so.

Copyright, 1967, by the Hawaii Medical Association, Honolulu, Hawaii. Entered as second class matter, October 17, 1941, at the Post Office in Honolulu, Hawaii, under the Act of August 24, 1912. Office of Publication: Mabel L. Smyth Memorial Building, 510 S. Beretania St., Honolulu, Hawaii 96813.




# JAMES C. CHOY

**Member, Hawaii Estate Planning Council**
**Winner, National Quality Award**
**15 Consecutive Years**

Doctors, more than most people, are aware that no one can predict the future. But you can provide for it through life insurance. Few things can create an estate as surely, as quickly. It is the one means by which a doctor can give his family basic financial protection *immediately*.

And if you're setting up a retirement fund for yourself and your employees, New York Life has a plan which will help you take full advantage of both current and future tax provisions under the Keogh Law.

Placing any insurance policy carries with it a promise of service. For the past 18 years, as a full-time representative of one of the strongest mutual life insurance companies, I have specialized in the individual problems of the medical profession. I have the experience to serve you. Call me for an appointment—there is no obligation, of course.

**JAMES C. CHOY**
**NEW YORK LIFE INSURANCE COMPANY**
**235 Queen Street, Honolulu 96813**
**Telephone: 583-811**

NEW YORK LIFE

HAWAII MEDICAL JOURNAL

# Contents

Volume 26, No. 6 • July-August, 1967

**Articles**

*Presidential Address* 529
Theodore T. Tomita

*Multiple Myeloma and Macroglobulinemia Cases in Hawaii* 531
William Hartman, B.S., Remedios Farin, B.S., and Mitsuo Yokoyama, M.D.

*Differential Mortality in Honolulu Before 1900* 537
Robert C. Schmitt, M.A.

*First National Congress on the Socio-Economics of Health Care* 543
Rodney T. West, M.D.

*Typhoid Fever* 547
Ralph B. Berry, M.D.

**Editorials**

*Generic Equivalence* 549
*Medic Alert Saves Lives* 550
*The* Real *St. Francis Hospital* 550

**Features**

*Annual Index* 634
*Book Reviews* 554
*County Society Reports* 556
*Hawaii Academy of General Practice* 553
*Hawaii Medical Association* 560
*In Memoriam—Doctors of Hawaii—LXVII* 552
*New Members* 556
*Notes and News* 557
*Our New President* 559
*President's Page* 548
*This Is What's New!* 551
*University of Hawaii* 555

**Hawaii Technologists' Bulletin**

*Meet Your Officers—1967-68* 614
*HSMT's Scholarship—First Recipient* 615
*1967-68 Interning Students* 615

# That "simple will" of yours could cost your family thousands of dollars..

***...cut those losses with the help of BISHOP TRUST***

All too often, a busy medical man has little or no time to devote to his personal financial affairs. Yet while he's building up his practice, the value of his estate is also increasing. And the "simple will" that was perfectly adequate for distributing an estate of $70,000 could be disastrous if that estate has grown to, say, $400,000.

Federal estate taxes in such a situation could exceed $110,000 by the time the property passed from a man to his wife, and then to their children. Yet a new will, one that took advantage of our trust services, could help cut those losses by as much as $47,000.

Bishop Trust has been helping busy professional people since 1906. We are a pure trust company, one whose success has always depended on the quality of the services we provide. Thanks to this experience, we are uniquely qualified to do the best possible job for you and your family.

Whether we serve you as investment adviser, trustee under living, testamentary, or retirement trusts, or executor under your will, we will give your affairs the specialized, individual attention that is so important. Phone us without obligation for an appointment at any time, either in your home or at our offices.

BISHOP TRUST COMPANY

BISHOP AND KING STREETS · PHONE 563-771
Service to Neighbor Island residents by personal visit

The AMBAR SCRAPBOOK of

# Obesity Oddities

FACT & LEGEND

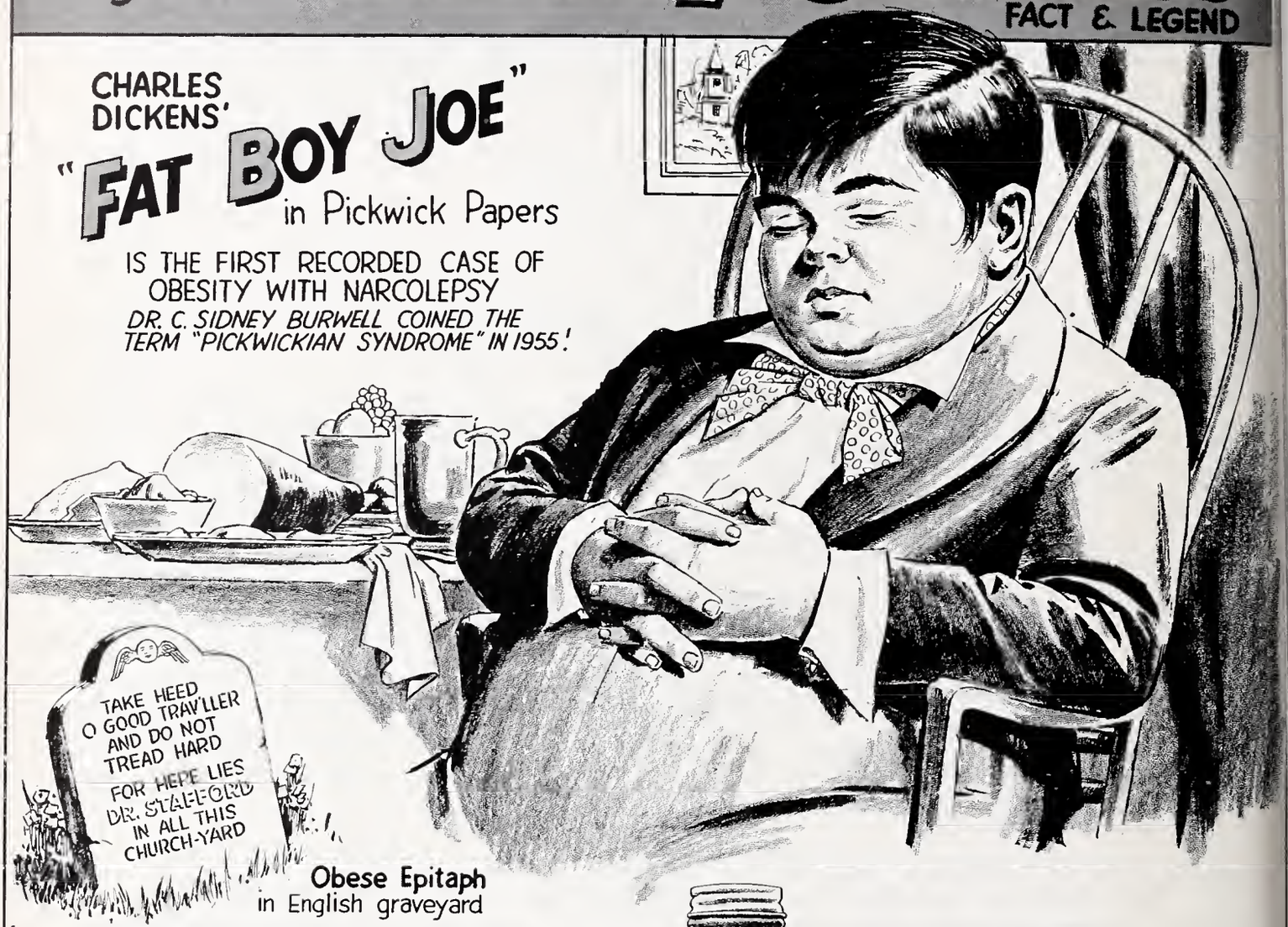
CHARLES DICKENS'

## "FAT BOY JOE"

in Pickwick Papers

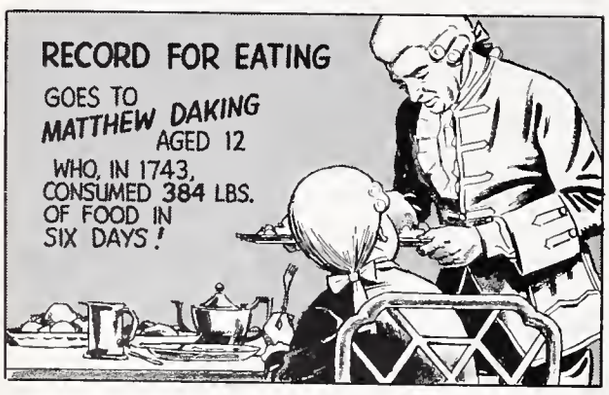
IS THE FIRST RECORDED CASE OF OBESITY WITH NARCOLEPSY

*DR. C. SIDNEY BURWELL COINED THE TERM "PICKWICKIAN SYNDROME" IN 1955!*





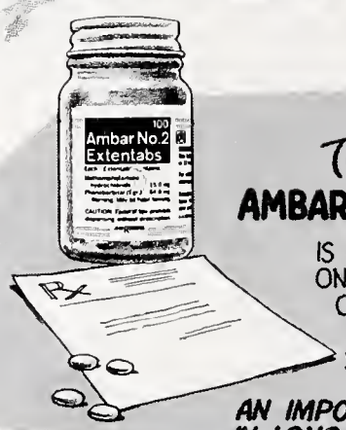

**Obese Epitaph**
in English graveyard



**RECORD FOR EATING**

GOES TO **MATTHEW DAKING** AGED 12

WHO, IN 1743, CONSUMED 384 LBS. OF FOOD IN SIX DAYS!




THE Cost of **AMBAR EXTENTABS**

IS APPROXIMATELY ONE-HALF THAT OF OTHER LEADING APPETITE SUPPRESSANTS.



*AN IMPORTANT FACTOR IN LONG-TERM THERAPY!*

## CONTROL FOOD AND MOOD ALL DAY LONG WITH A SINGLE MORNING DOSE

# AMBAR #2 EXTENTABS®

methamphetamine HCl 15 mg., phenobarbital 64.8 mg. (1 gr.) (Warning: may be habit forming).

One Ambar Extentab before breakfast can help control most patients' appetite for up to 12 hours. Methamphetamine, the appetite suppressant, gently elevates mood and helps overcome dieting frustrations. Phenobarbital, the sedative in Ambar, controls irritability and anxiety... helps maintain a state of mental calm and equanimity. Both work together to ease the tensions that erode the willpower during periods of dieting.

Also available: Ambar #1 Extentabs®—methamphetamine hydrochloride 10 mg., phenobarbital 64.8 mg. (1 gr.) (Warning: may be habit forming).

BRIEF SUMMARY/**Indications:** Ambar suppresses appetite and helps offset emotional reactions to dieting. **Contraindications:** Hypersensitivity to barbiturates or sympathomimetics; patients with advanced renal or hepatic disease. **Precautions:** Administer with caution in the presence of cardiovascular disease or hypertension. **Side Effects:** Nervousness or excitement occasionally noted, but usually infrequent at recommended dosages. Slight drowsiness has been reported rarely. See package insert for further details.

A. H. ROBINS COMPANY, RICHMOND, VA. 23220

A·H·ROBINS



# CONFIDENTIAL LOAN PLAN FOR PHYSICIANS

## BORROW UP TO $10,000 • TAKE UP TO 4 YEARS TO REPAY • ENJOY INDUSTRIAL BANK RATES

Finance Factors recognizes that members of the medical profession, like many businesses and corporations, need fast cash for immediate opportunities. We therefore offer to physicians this exclusive personal loan plan, **conducted in strictest confidence and on an executive level only.** Rapid action. No inconvenience.

We invite you to telephone either of the two vice presidents listed below. These telephone numbers are direct lines for executives and do not go through our switchboard.

ABRAHAM HO, VICE PRESIDENT & SENIOR LOAN OFFICER.....5439426
EDWARD MATSUMOTO, SENIOR VICE PRESIDENT.....5439441

Or write to either of these officers in care of Finance Factors, Post Office Box 3979, Honolulu 96812 — mark your inquiry "Personal & Confidential."

**SCHEDULE OF MONTHLY REPAYMENTS**
(examples)

| AMOUNT DESIRED | 24 MOS. | 36 MOS. | 48 MOS. |
|---|---|---|---|
| $ 1,000 | $ 51.00 | $ 37.00 | $ 29.00 |
| 1,500 | 76.00 | 55.00 | 43.00 |
| 2,000 | 101.00 | 73.00 | 58.00 |
| 2,500 | 126.00 | 91.00 | 72.00 |
| 5,000 | 251.00 | 182.00 | 143.00 |
| 10,000 | 493.00 | 355.00 | 286.00 |

Finance Factors LIMITED





# Tissue's healing nicely. Yet anxiety slows his steps toward recovery.

By helping overcome anxiety and tension which can thwart the convalescent's progress, EQUANIL (meprobamate) often may play an important role in medical and surgical aftercare.

**Cautions:** Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use may result in dependence or habituation in susceptible persons—as ex-addicts, alcoholics, severe psychoneurotics. After prolonged high dosage, drug should be withdrawn gradually to avoid possibly severe withdrawal reactions including epileptiform seizures. Side effects include drowsiness and, rarely, allergic or idiosyncratic reactions. These reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Mild reactions are characterized by urticarial or erythematous maculopapular rash. Acute non-thrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever have been reported. If an allergic reaction occurs, meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioneurotic edema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. Warn patients of possible reduced alcohol tolerance. Should drowsiness, ataxia, or visual disturbances occur, dose should be reduced. If symptoms persist, patients should not operate vehicles or dangerous machinery. A few cases of leucopenia, usually transient, have been reported following prolonged dosage. Other blood dyscrasias—aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis and hemolytic anemia—have occurred rarely, almost always in the presence of known toxic agents. One fatal case of bullous dermatitis following intermittent use of meprobamate with prednisolone has been reported. Prescribe very cautiously for patients with suicidal tendencies. Suicidal attempts should be treated with immediate gastric lavage and appropriate supportive therapy.

**Contraindications:** History of sensitivity to meprobamate.

**Composition:** Tablets, 200 mg. and 400 mg. meprobamate. Coated Tablets, WYSEALS® EQUANIL (meprobamate) 400 mg. Continuous-Release Capsules, EQUANIL L-A (meprobamate) 400 mg.

Wyeth Laboratories
Philadelphia, Pa.

Wyeth ® SERVICE TO MEDICINE

# Equanil®
## (meprobamate)
## Wyeth

Professionally posed.

# In peptic ulcer... antacid therapy with a new benefit



CONTAINS A BALANCED COMBINATION OF THE MOST WIDELY USED ANTACIDS— FOR RAPID NEUTRALIZATION. PLUS SIMETHICONE— TO CONTROL THE FACTOR WHICH ANTACIDS ALONE CANNOT INFLUENCE.

# Mylanta®

- In Mylanta, aluminum and magnesium hydroxides are balanced to minimize the chance of constipation or laxation and still achieve rapid acid neutralization and pain relief.
- The positive action of simethicone helps relieve the painful gas symptoms which often accompany the peptic ulcer syndrome.
- The nonfatiguing flavor and smooth, nongritty consistency of tablets and liquid encourage continued patient cooperation during long-term therapy.

**Composition:** Each Mylanta chewable tablet or teaspoonful (5 ml.) of liquid contains: magnesium hydroxide, 200 mg.; aluminum hydroxide, dried gel, 200 mg.; simethicone, 20 mg. **Dosage:** one or two tablets, well chewed or allowed to dissolve in the mouth, or one or two teaspoonfuls of liquid to be taken between meals and at bedtime.

**The Stuart Company,** Pasadena, California
Division of Atlas Chemical Industries, Inc.

Stuart

# WHEN ANXIETY IS A SIGNIFICANT COMPONENT OF THE CLINICAL PROFILE

# LIBRIUM®
## (chlordiazepoxide HCl)

**Also available as**
**LIBRITABS[T.M.] (chlordiazepoxide)**
**5-mg, 10-mg, 25-mg tablets**

ROCHE

Before prescribing, please consult complete product information, a summary of which follows:

**Contraindications:** Patients with known hypersensitivity to the drug.

**Warnings:** Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

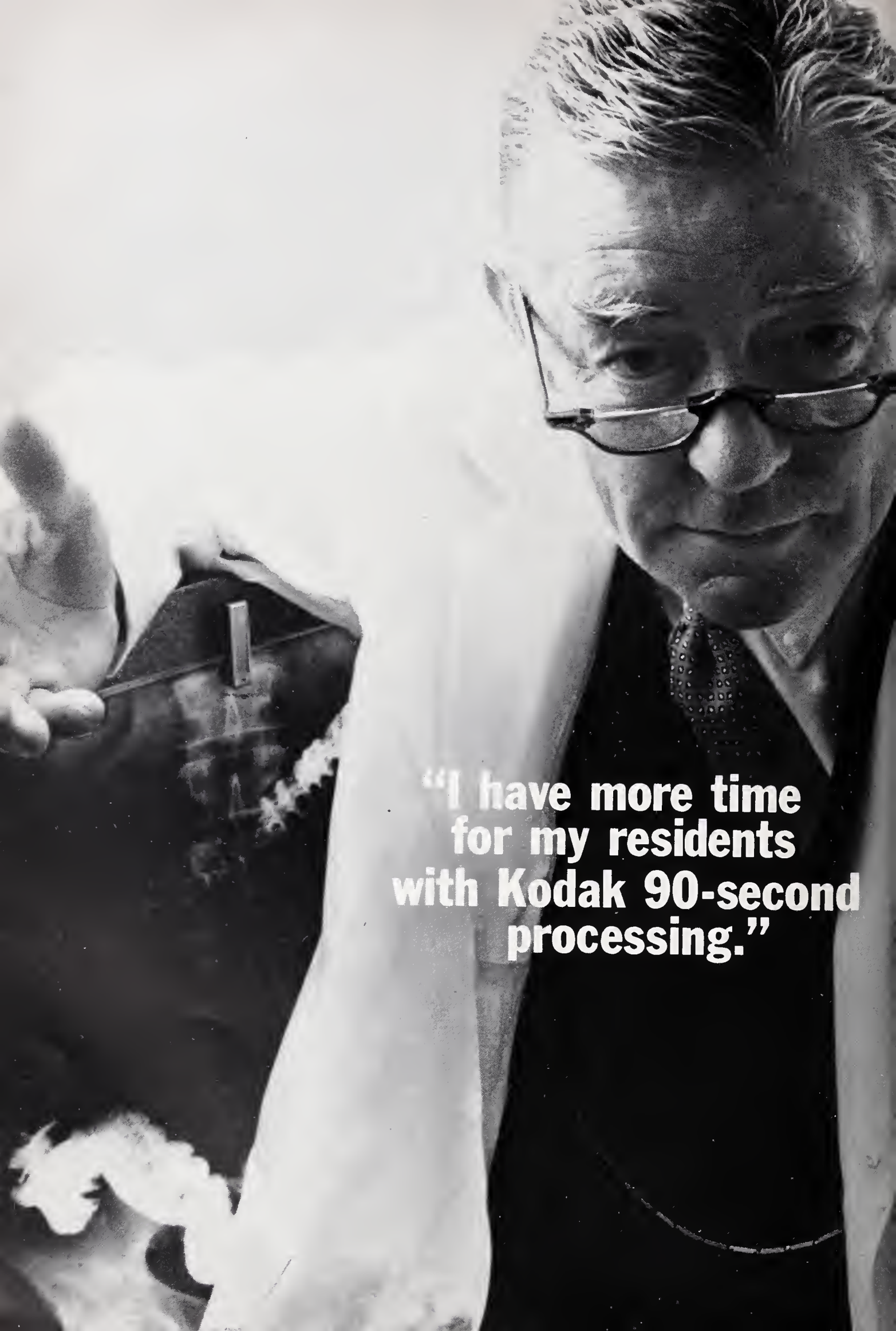
**Precautions:** In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

**Adverse Reactions:** Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver-function tests advisable during protracted therapy.

**Usual Daily Dosage:** Individualize for maximum beneficial effects. *Oral*—Adults: Mild and moderate anxiety and tension, 5 or 10 mg t.i.d. or q.i.d.; severe states, 20 or 25 mg t.i.d. or q.i.d. Geriatric patients: 5 mg b.i.d. to q.i.d. (See Precautions.)

**Supplied:** Librium® (chlordiazepoxide HCl) Capsules, 5 mg, 10 mg and 25 mg—bottles of 50. Libritabs[T.M.] (chlordiazepoxide) Tablets, 5 mg, 10 mg and 25 mg—bottles of 100. With respect to clinical activity, capsules and tablets are indistinguishable.

**Roche Laboratories** • Division of Hoffmann-La Roche Inc • Nutley, N.J. 07110


"I have more time
for my residents
with Kodak 90-second
processing."



This is what converting to the Kodak RP X-omat® System meant to the chief radiologist in a 200-bed hospital. "There has been less confusion, faster service, smoother patient flow, and greater capacity," he told us. "Staff can be employed more efficiently."

All important, the Kodak RP X-omat System assures excellent-quality radiographs. Kodak RP X-omat Medical X-ray Film gives you speed and contrast equal to famed Kodak Blue Brand Film. The faster speed Kodak RP/S X-omat Medical X-ray Film permits shorter exposures, has higher contrast.

Ask your Kodak X-omat dealer or Kodak Technical Sales Representative about the new Kodak RP X-omat Processor, Model M6. Or most existing X-omat Processors can be modified to 90-second rapid processing.

**EASTMAN KODAK COMPANY**
**Radiography Markets Division**
**Rochester, New York**

Kodak
TRADEMARK


Preludin
phenmetrazine
hydrochloride

# helps keep calories at arm's length



Most persons have a tendency to regain lost weight easily. Preludin is made to order for such patients. It effectively curbs appetite and helps them stick to their diets.

*Preludin keeps patients active.* Because moderate exercise is usually more feasible for patients who are not grossly overweight, Preludin should be doubly beneficial for them. It promotes a sense of well-being that activates patients... makes them feel like doing things... and prompts them to get the exercise your weight-control program calls for.

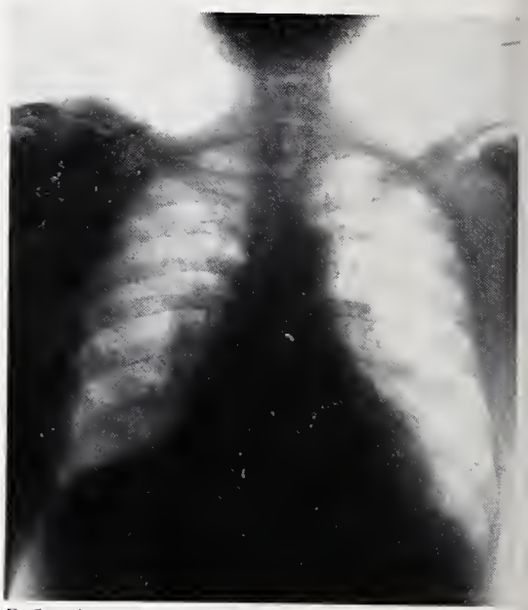
*Preludin effectively reduces appetite*. Preludin's ability to help patients shed weight has been described in more than 300 published clinical reports involving more than 10,000 patients. It will work in your weight-control programs too.

Preludin® tablets of 25 mg.
Endurets® prolonged-action tablets of 75 mg.
*Dosage:* One 25 mg. tablet two or three times daily, or one 75 mg. Endurets tablet once daily.
*Contraindications:* Severe coronary artery disease, hyperthyroidism, severe hypertension, nervous instability, and agitated prepsychotic states. Do not use with other CNS stimulants, including MAO inhibitors.
*Warning:* Do not use during the first trimester of pregnancy unless potential benefits outweigh possible risks.
*Precautions:* Use with caution in moderate hypertension and cardiac decompensation. Cases involving abuse of or dependence on phenmetrazine hydrochloride have resulted in a psychotic illness manifested by restlessness, mood or behavior changes, hallucinations, or delusions. Do not exceed recommended dosage.
*Side Effects:* Dryness or unpleasant taste in the mouth, urticaria, and (rarely) overstimulation, insomnia, dizziness, nausea, urinary frequency or nocturia, or headache.
For complete details, please see full Prescribing Information. (B)46-560A

Under license from Boehringer Ingelheim G.m.b.H.

Geigy Pharmaceuticals, Division of
Geigy Chemical Corporation, Ardsley, New York

# In chronic respiratory infections:



Diffused mottling in lower right lobe consistent with bronchopneumonia.



Direct bronchoscopy reveals a chronic inflammatory response.



Spirometer measuring pneumo-capacity, useful in evaluating degree of emphysema.

# You can minimize recurrence with this single bactericidal broad-spectrum agent.

Now, instead of tetracycline, penicillin-streptomycin or chloramphenicol, you can use a single broad-spectrum antibiotic—Polycillin (ampicillin trihydrate)—against bacterial infections in pulmonary emphysema, chronic bronchitis and pneumonia.[1-6] Bactericidal against *D. pneumoniae*, Polycillin (ampicillin trihydrate) is also more active than tetracycline or chloramphenicol against *H. influenzae* and many other Gram-negative pathogens. It is well tolerated and without direct toxicity in high or prolonged dosage.

Chronic bronchitis, where pneumococci often accompany the predominant *H. influenzae*, is thus a major indication for Polycillin (ampicillin trihydrate).[4] And when pneumococci are the sole pathogens, controlled clinical trial has shown that it can produce early defervescence more often than parenteral penicillin-streptomycin.[5] While Polycillin (ampicillin trihydrate) cannot reverse structural pathology, it does offer a new and practical way to minimize the chronicity of associated bacterial respiratory infection.

References: 1. May, J. R.: Postgrad. M. J. *40*:193, Suppl., (Dec.) 1964. 2. Millard, F.J.C.: Geriatrics *20*:854 (Oct.) 1965. 3. Lyons, H.A.: M.Times 93:1386 (Dec.) 1965. 4. Council on Drugs: JAMA *191*:1071 (Mar. 29) 1965. 5. Crofton, J.W., *et al.*: Brit. M.J. *1*:1329 (May 28) 1966. 6. Lyons, H.A.: JAMA *194*:1234 (Dec. 13) 1965.

BRISTOL

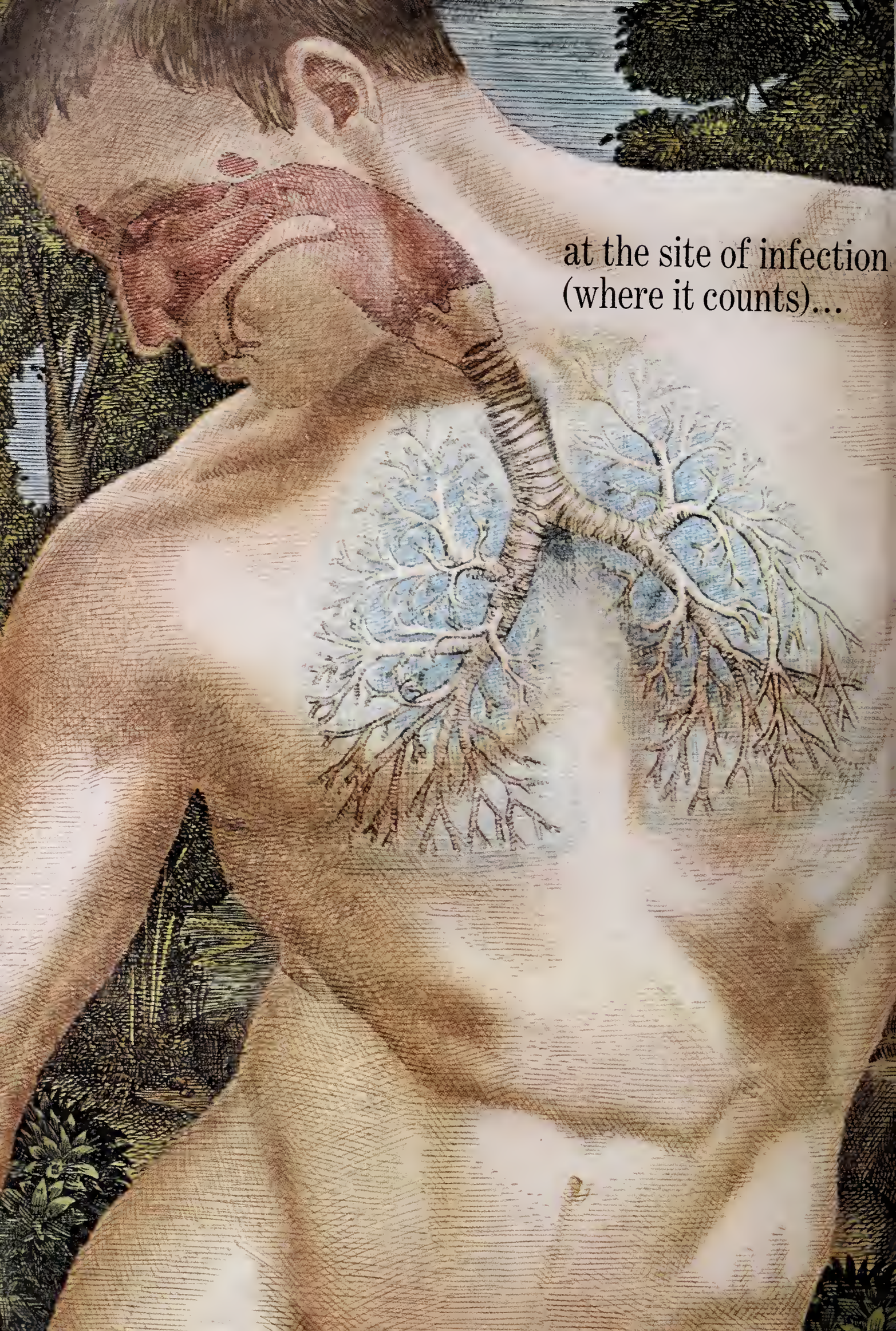
BRISTOL LABORATORIES/Division of Bristol-Myers Co. Syracuse, New York

PRESCRIBING INFORMATION. For complete information consult Official Package Circular. *Indications:* Infections due to susceptible strains of Gram-negative bacteria (including Shigellae, *S. typhosa* and other Salmonellae, *E. coli*, *H. influenzae*, *P. mirabilis*, *N. gonorrhoeae* and *N. meningitidis*) and Gram-positive bacteria (including streptococci, pneumococci and nonpenicillinase-producing staphylococci). *Contraindications:* A history of allergic reactions to penicillin and infections due to penicillinase-producing organisms. *Precautions:* Typical penicillin-allergic reactions may occur, especially in hypersensitive patients. Mycotic or bacterial superinfections may occur. Experience in newborn and premature infants is limited and caution should be used in treatment, with frequent organ function evaluations. Safety for use in pregnancy is not established. In gonorrheal therapy, serologic tests for syphilis should be performed initially and monthly for 3 months. Assess renal, hepatic and hematopoietic function intermittently during long-term therapy. *Adverse Reactions:* Skin rash, pruritus, urticaria, nausea, vomiting, diarrhea and anaphylactic reactions. Mild transient elevations of SGOT or SGPT have been noted. *Usual Dosage:* Adults —250 or 500 mg. *q.* 6 *h.* (according to infection site and offending organisms). Children—50-100 mg./Kg./day in 3 to 4 divided doses (depending on infection site and offending organisms). Children weighing more than 20 Kg. should be given an adult dose. Beta-hemolytic streptococcal infections should be treated for at least 10 days. *Supplied:* Capsules—250 mg. in bottles of 24 and 100. 500 mg. in bottles of 16. For Oral Suspension—125 mg./5 ml. in 60, 80, and 150 ml. bottles. 250 mg./5 ml. in 80 ml. bottles. Injectable—for I.M./I.V. use—vials of 125 mg., 250 mg., 500 mg., and 1 Gm.

A.H.F.S. Category 8:12.16

**Polycillin®**
(ampicillin trihydrate)

the penicillin you use like a broad-spectrum antibiotic


at the site of infection
(where it counts)...

# Ilosone® provides more antibacterial activity than any other oral erythromycin

**Acid stable, better absorbed ... Ilosone produces faster, higher, more prolonged blood levels, even in the presence of food[1-3]**

Because it is the most active form of oral erythromycin, Ilosone can help assure consistently greater antibacterial activity at the site of infection. Ilosone produces peak antibacterial blood levels two to four times those of other erythromycin preparations.[1,2] Not only are these levels attained earlier, but they are maintained for much longer periods. Even the presence of food does not seem to affect the activity of Ilosone.[1,3]

In the treatment of patients with bacterial infections susceptible to erythromycin, Ilosone has compiled an excellent therapeutic record. Since it exerts its greatest activity against gram-positive organisms, it is particularly useful in common respiratory and soft-tissue bacterial infections. Ilosone kills—not merely inhibits—streptococci, pneumococci, and more strains of staphylococci than any other macrolide antibiotic. This bactericidal action, coupled with the high antibacterial levels attained, makes Ilosone especially valuable in patients with low host resistance, such as infants, debilitated individuals, and diabetics.

Ilosone has shown no cross-resistance with penicillin and may be effective against organisms that have become resistant to that agent. Despite its high antibacterial activity, Ilosone has demonstrated a low incidence of side reactions. Blood dyscrasias, ototoxicity, and tooth staining have not been observed. Infrequent cases of drug idiosyncrasy, manifested by a cholestatic jaundice, have occurred, but there have been no known definite residual effects.

**Now available:**
New! Ready-mixed Ilosone Liquid 125! (Contains erythromycin estolate equivalent to 125 mg. erythromycin base per 5-cc. teaspoonful.)

700970

Ilosone®
Erythromycin Estolate

Lilly

*(See next page for prescribing information.)*

# Ilosone®/ the most active oral form of erythromycin

**Description:** Ilosone is the most active form of oral erythromycin that has been developed. Because it is stable in acid, well absorbed, and excreted in lesser amounts in the bile, it provides faster, higher, and longer-lasting levels of antibacterial activity (ABA) in the serum, even when taken with food, than do comparable doses of erythromycin.

**Indications:** Ilosone is indicated in infections caused by microorganisms sensitive to its action (especially staphylococci, hemolytic streptococci, and pneumococci). The drug is therefore useful in a high proportion of bacterial diseases encountered in clinical practice and particularly in the treatment of bacterial infections of the upper and lower respiratory tract and soft tissues.

In the treatment of acute bacterial pharyngitis and tonsillitis, this antibiotic has promptly eradicated the bacteria (streptococci) and has produced a parallel prompt clinical improvement. There have been no group A beta-hemolytic streptococci resistant to this preparation. In beta-hemolytic streptococcus infections, treatment should be maintained for ten days to prevent the development of rheumatic fever or glomerulonephritis.

Erythromycin estolate has proved to be very effective in pneumococcus pneumonia and in acute bronchitis with pneumococci on culture. Bronchopneumonia and otitis media in children have responded well to its use.

The antibiotic has been used very successfully in staphylococcus infections. Good therapeutic results have been obtained in soft-tissue infections, abscesses, cellulitis, carbuncles, wound infections, and furunculosis.

In serious staphylococcus infections, erythromycin preparations should be used only in combination therapy with other antimicrobial agents. As is the case with any treatment regimen used in these severe conditions, surgical procedures should be performed when indicated, and large dosages of the antimicrobial agents should be employed. In this fashion, Ilosone has been effective in staphylococcus pneumonia, osteomyelitis, septicemia, empyema, and meningitis.

Multiple 500-mg. doses of the drug have also been useful in gonorrhea and syphilis. Since penicillin is the drug of choice for the treatment of syphilis and gonorrhea, erythromycin estolate should be employed for these infections only in patients with a history of penicillin allergy. Also, other infections due to susceptible bacteria in patients known to be hypersensitive to penicillin or other antibiotics may be considered for treatment with Ilosone.

**Contraindications: Ilosone is contraindicated in patients with a known history of sensitivity to this drug and in those with preexisting liver disease or dysfunction.**

**Adverse Reactions:** Data obtained from seven years' use of propionyl erythromycin ester and erythromycin estolate (Ilosone) indicate that hepatic dysfunction with or without clinical jaundice may occur during or following courses of therapy with the drug.

Changes in liver function tests in such cases have been indicative of intrahepatic cholestasis. The symptoms appear to be the result of a form of sensitization. The initial symptoms have developed in some cases after a few days of treatment but generally have followed one or two weeks of continuous therapy or several courses of the drug. Symptoms reappear promptly, usually within forty-eight hours, if the drug is readministered to sensitive patients. Eosinophilia was noted in peripheral blood counts. The findings readily subsided without apparent residual effects when treatment was discontinued. Recovery was delayed in one reported instance. The physician indicated in this case that either drug-induced jaundice or viral hepatitis may have been responsible for the findings.

In one clinical study involving ninety-three patients treated with the antibiotic, three cases of jaundice were observed and an additional eleven cases developed some changes in liver function tests. Three of the patients had abnormal liver function tests a second time on readministration of the drug.

Even though it is assumed that not all cases of jaundice have been reported, it seems clear that the number is small compared with the amount of drug that has been used. Reported cases have included persons in whom there had been administered other drugs known to be associated at times with hepatic side-effects and cases in which the presence of viral hepatitis or other disease may have been responsible for the findings. In some of the cases, associated gastro-intestinal symptoms simulated the colic of biliary tract disease. In other instances, clinical symptoms and results of liver function tests resembled findings in extrahepatic obstructive jaundice. It appears that the occurrence of jaundice after administration of Ilosone is infrequent, but further investigations are being made to estimate its incidence more accurately.

In those cases mentioned above in which jaundice appeared be definitely related to use of the drug, laboratory findings we characterized by increased direct-reacting bilirubin, elevat alkaline phosphatase levels, negative or weakly positive cephal flocculation and thymol turbidity tests, elevated serum glutam oxalacetic transaminase levels, peripheral eosinophilia, and no mal cholecystograms.

Individual idiosyncrasy seems evident since jaundice has n been reported in other patients taking prolonged courses of tl medication. Patients with chronic infection have been given 1 to 2 Gm. of the drug daily for periods of two to six months, ar patients with rheumatic fever have taken prophylactic doses 0.5 Gm. daily for two years without difficulty. In one group 144 patients who received the drug daily for two years, no jau dice was noted. It was of interest that members of six of the patients' families, who were not taking the drug, had episod of jaundice during the study period.

Transaminase and serum alkaline phosphatase levels we determined in a group of fifty-four adults and children who too 250 mg. of Ilosone daily for an average of sixteen months a rheumatic fever prophylaxis. The results were compared wit those of a similar group of forty-four patients who received pen icillin. There were no cases of jaundice in either group. Elevatio of SGPT and serum alkaline phosphatase levels during the cours of treatment was observed in one patient treated with Ilosone and in two patients treated with penicillin. Seven other patient in the group receiving Ilosone and four others in the penicilli group showed elevations in one of the tests at some time during administration of the drugs.

Very satisfactory therapeutic results, without toxicity, were reported in 102 pediatric patients who received short-term (ten day) courses of Ilosone in the treatment of streptococcus infections. Results of liver function tests in these patients were comparable to those in a similar control group who had received penicillin.

Gastro-intestinal disturbances not associated with hepatic effects are observed in a small proportion of individuals as a result of a local stimulating effect of the medication on the alimentary tract; however, the normal intestinal gram-negative bacterial flora is not appreciably altered by erythromycin drugs.

Although allergic manifestations are uncommon with the use of erythromycin, there have been occasional reports of urticaria, skin eruptions, and, on rare occasions, anaphylaxis.

**Administration and Dosage:** Ilosone is administered orally.

Ilosone Pulvules®, Ilosone Liquid 125, Ilosone, 125, for Oral Suspension, Ilosone Drops, Ilosone Chewable Tablets.

For infants and for children under twenty-five pounds of body weight, the usual dosage is 5 mg. per pound every six hours; for children twenty-five to fifty pounds, 125 mg. every six hours. (Tablets Ilosone Chewable should be chewed or crushed and swallowed with water.)

For adults and for children over fifty pounds, the usual dosage of Ilosone is 250 mg. every six hours.

For severe infections, these dosages may be doubled.

When larger doses are indicated, parenteral erythromycin therapy should be considered.

In the treatment of syphilis, the recommended total dosage is 20 to 30 Gm. given in divided doses for a period of ten to fifteen days. Close follow-up of the patient is necessary since erythromycin drugs have not had adequate evaluation in all stages of syphilis. Examinations of spinal fluid are recommended as part of the follow-up therapy.

For gonorrhea, 500 mg. four times a day for four days are recommended. In the treatment of gonorrhea, patients with a suspected lesion of syphilis should have a dark-field examination before receiving antibiotics, and monthly serologic tests should be made for a period of three months.

**How Supplied:** Pulvules Ilosone, Capsules, N.F., 125 and 250 mg. (equivalent to base), in bottles of 24 and 100.

Ilosone Liquid 125, Oral Suspension, U.S.P., 125 mg. (equivalent to base) per 5-cc. teaspoonful, in 60-cc. and pint-size packages.

Ilosone, 125, for Oral Suspension, N.F., 125 mg. (equivalent to base) per 5-cc. teaspoonful, in 60 and 150-cc.-size packages.

Ilosone Drops, 5 mg. (equivalent to base) per drop, in 10-cc.-size packages, with dropper calibrated at 25 and 50 mg.

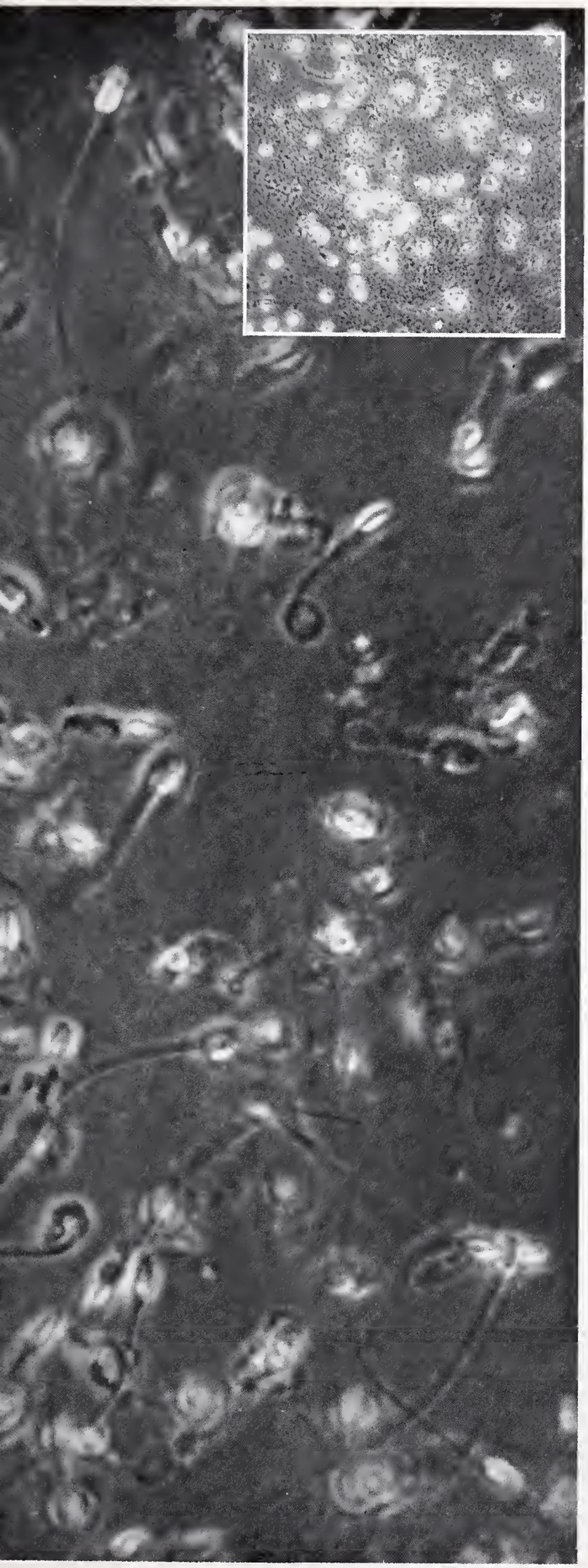
Tablets Ilosone Chewable, N.F., 125 mg. (equivalent to base), in bottles of 50. [032767]

*References:* 1. Griffith, R. S., and Black, H. R.: Am. J. M. Sc., *247*:69, 1964. 2. Griffith, R. S., and Black, H. R.: Antibiotics & Chemother., *12*:398, 1962. 3. Hirsch, H. A., Pryles, C. V., and Finland, M.: Am. J. M. Sc., *239*:198, 1960.

*Additional information available to physicians upon request.*
*Eli Lilly and Company, Indianapolis, Indiana 46206.*

Lilly

700970



# New view of an oral contraceptive at work

Although suppression of ovulation remains the primary mode of action of oral contraceptives, newer knowledge indicates that products like Norinyl-1—a combination of both low-dosage progestogen and estrogen for the full treatment cycle—may provide multiple action that helps explain their unexcelled record of contraceptive effectiveness. This report explores the possible secondary protective mechanisms offered by combined hormonal administration.

Accumulating evidence has indicated that sparse, highly viscous cervical mucus has a possible adverse effect on the motility and survival of spermatozoa.

The estrogen-opposing progestational ingredient of Norinyl-1 (norethindrone 1 mg. with mestranol 0.05 mg.) changes the usual midcycle picture of a thin, watery cervical mucus. The result—a built-in barrier that appears to inhibit sperm from reaching the ovum should one be released. The inset in the adjoining photograph shows immobile spermatozoa as they appear in cervical mucus taken from a patient treated with Norinyl-1.

See last page for contraindications, precautions, side effects and dosage.

# How the estrogen-opposing action of Norinyl-1 creates cervical mucus that may be hostile to sperm penetration

Normally, estrogen activity during the fertile midcycle stimulates the production of a profuse and watery cervical mucus that permits maximum sperm motility and promotes penetration.

But what happens when Norinyl-1 is administered? Its potent progestogen, norethindrone, opposes estrogen stimulation of cervical mucus. Consequently, the amount of mucus decreases and its viscosity increases. This results in a sparse but thick mucus barrier that appears to diminish the vitality of the sperm and to impair its powers of penetration.

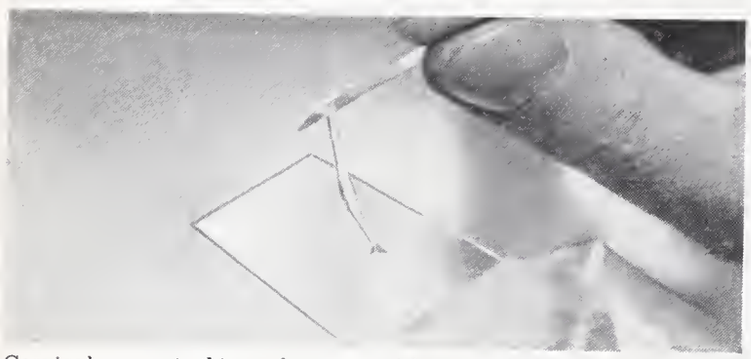
## The role of viscous cervical mucus as a secondary action of Norinyl-1

In a report on 89 patients taking this medication,* cervical mucus obtained from cycle day 5 to cycle day 29 appeared scant and thick and exhibited little or no Spinnbarkeit.

In the opinion of this investigator, the effect on cervical mucus may be sufficient to prevent conception.

*Cohen, M. R.: Symposium: Mechanisms of Action of Low Dosage Oral Contraceptive, Yale University Medical Center, New Haven, Conn., April 6, 1967.

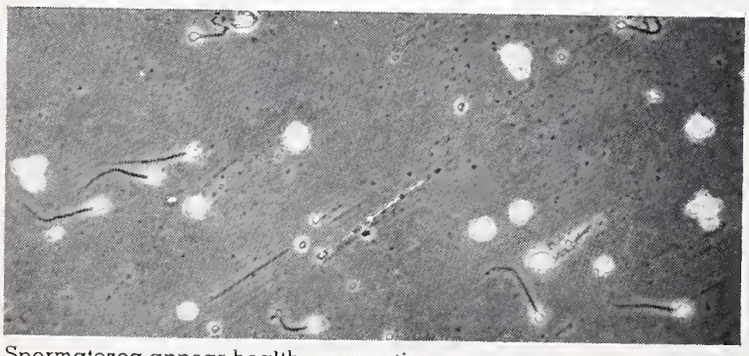
### Normal cervical mucus at midcycle in untreated patient is known to permit sperm motility... promote sperm penetration.



Cervical mucus is thin and watery with a stretchability (Spinnbarkeit) of 15 to 20 cm.

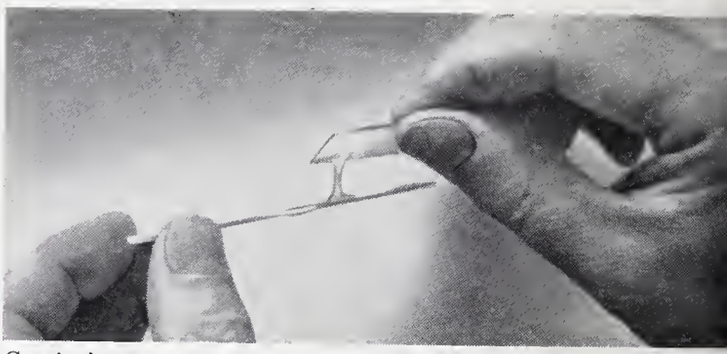


Thin, watery mucus crystallizes into this well-defined, fernlike pattern within a minute.

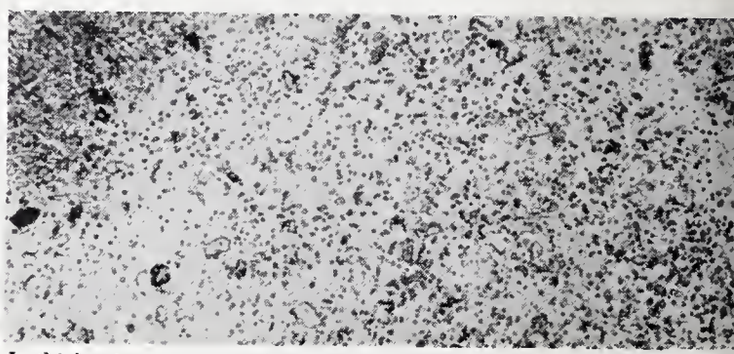


Spermatozoa appear healthy, are active and freemoving.

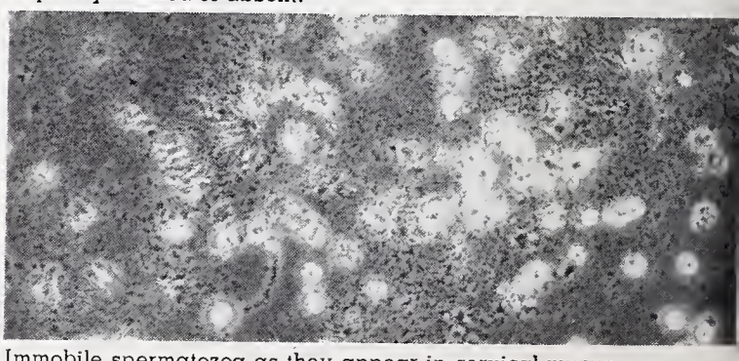
### Viscous cervical mucus at midcycle produced by Norinyl-1 appears to impair sperm vitality... inhibit penetration.



Cervical mucus is scanty, thick and viscous. Spinnbarkeit is 1 cm. or less.



In thick, viscous cervical mucus the fern pattern is poorly defined or absent.



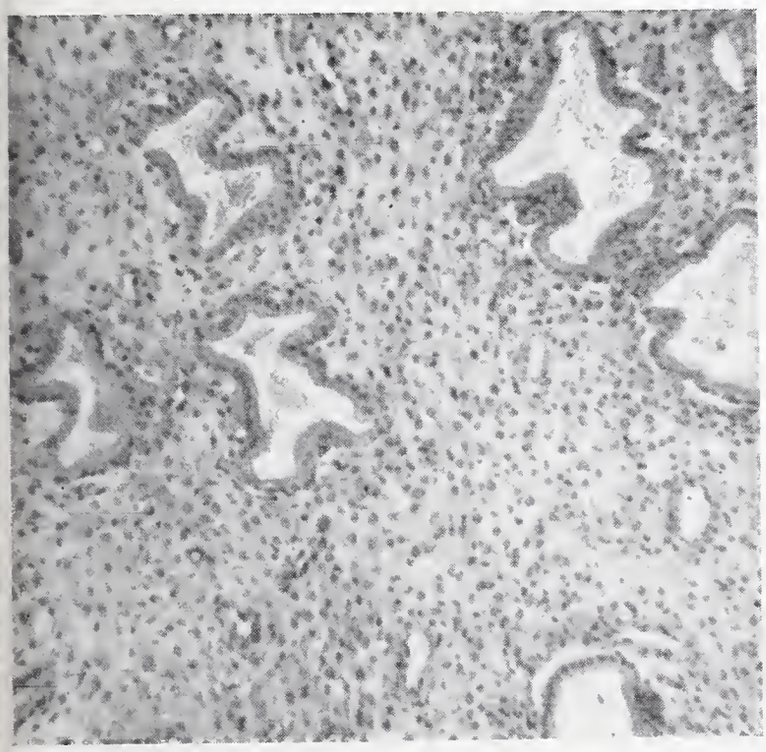
Immobile spermatozoa as they appear in cervical mucus taken from a patient treated with Norinyl-1.

# How Norinyl-1 alters normal endometrial responses—another possible protective mechanism

Let us suppose that an ovum is released—as occurs in an occasional, rare case—and somehow a sperm succeeds in penetrating the cervical mucus barrier. Should this come about, one additional action of Norinyl-1 may protect the patient from unwanted pregnancy. The theory is that progestogen intake makes endometrial tissue unreceptive to implantation.

**Endometrium of untreated patient**

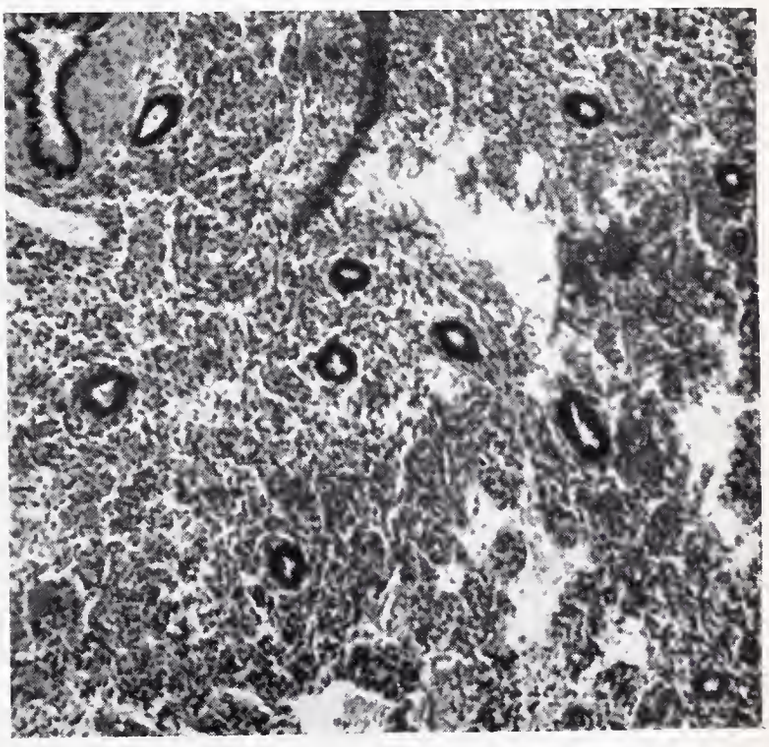




Normally, the endometrium progresses through a proliferative phase stimulated by estrogen and a secretory phase stimulated by progesterone. During the secretory phase the endometrium is receptive to the fertilized ovum.

**Endometrium produced by Norinyl-1**





When Norinyl-1 is administered its progestogen component—norethindrone—accelerates the secretory phase and suppresses glandular and vascular development.

new Norinyl-1® tablets

(norethindrone 1mg. & mestranol 0.05mg.)

See last page for contraindications, precautions, side effects and dosage.

effective fertility control
on half the previous dosage

maintains ratio
of the established
norethindrone/mestranol
combination

lower cost

# new Norinyl-1®

(norethindrone 1mg. c̄ mestranol 0.05mg.) tablets

Reduction of oral contraceptive dosage to lowest effective levels has become a well-accepted principle of conservative medical practice. In keeping with this view, Norinyl is now available in a new strength in which *both* norethindrone and mestranol are reduced 50 percent. Studies show that Norinyl-1 achieves fertility control with only 1.05 mg. of combined progestogen and estrogen per tablet.

Norethindrone was first reported for use as a progestational agent in human beings in 1955. Norethindrone 2 mg. with mestranol 0.1 mg., as an oral contraceptive, is currently in use by over 2,000,000 women. Clinical experience now establishes that Norinyl-1 also amply meets the criteria of reliability and safety.*

*Symposium on Low-Dosage Oral Contraception, Palo Alto, Calif., July 15, 1965.

**PRESCRIBING INFORMATION**

**Contraindications:** 1. Patients with thrombophlebitis or with a history of thrombophlebitis or pulmonary embolism. 2. Liver dysfunction or disease. 3. Patients with known or suspected carcinoma of the breast or genital organs. 4. Undiagnosed vaginal bleeding.

**Warnings:** 1. Discontinue medication pending examination if there is sudden partial or complete loss of vision or if there is a sudden onset of proptosis, diplopia, or migraine. If examination reveals papilledema or retinal vascular lesions, medication should be withdrawn. 2. Since the safety of Norinyl-1 in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods, pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule, the possibility of pregnancy should be considered at the time of the first missed period. 3. Detectable amounts of the active ingredients in oral contraceptives have been identified in the milk of mothers receiving these drugs. The significance of this dose to the infant has not been determined.

**Precautions:** 1. The pretreatment physical examination should include special reference to breast and pelvic organs, as well as a Papanicolaou smear. 2. Endocrine and possibly liver function tests may be affected by treatment with Norinyl-1. Therefore, if such tests are abnormal in a patient taking Norinyl-1, it is recommended that they be repeated after the drug has been withdrawn for 2 months. 3. Under the influence of estrogen-progestogen preparations, preexisting uterine fibroids may increase in size. 4. Because these agents may cause some degree of fluid retention, conditions that may be influenced by this factor, such as epilepsy, migraine, asthma, cardiac, or renal dysfunction, require careful observation. 5. Although a cause and effect relationship has not been established, Norinyl-1 should be used with caution in patients with a history of cerebrovascular accident. 6. In relation to breakthrough bleeding, as in all cases of irregular bleeding *per vaginam*, nonfunctional causes should be borne in mind. In cases of undiagnosed vaginal bleeding, adequate diagnostic measures are indicated. 7. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. 8. Any possible influence of prolonged Norinyl-1 therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. 9. A decrease in glucose tolerance has been observed in a small percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving Norinyl-1 therapy. 10. Because of the occasional occurrence of thrombophlebitis and pulmonary embolism in patients taking oral contraceptives, the physician should be alert to the earliest manifestations of the disease. A cause and effect relationship has not been demonstrated. 11. Because of the effects of estrogens on epiphyseal closure, Norinyl-1 should be used judiciously in young patients in whom bone growth is not complete. 12. The age of the patient constitutes no absolute limiting factor, although treatment with Norinyl-1 may mask the onset of the climacteric. 13. The pathologist should be advised of Norinyl-1 therapy when relevant specimens are submitted.

**Side Effects:** The following adverse reactions have been observed with varying incidence in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms, breakthrough bleeding, spotting, change in menstrual flow, amenorrhea, edema, chloasma, breast changes (tenderness, enlargement and secretion), loss of scalp hair, change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately postpartum, cholestatic jaundice, erythema multiforme, erythema nodosum, hemorrhagic eruption, migraine, rash (allergic), itching, rise in blood pressure in susceptible individuals, mental depression.

The following occurrences have been observed in users of oral contraceptives. A cause and effect relationship has not been established: thrombophlebitis, pulmonary embolism, neuroocular lesions.

The following laboratory results may be altered by the use of oral contraceptives: increased bromsulphalein retention and other hepatic function tests, coagulation tests (increase in prothrombin, factors VII, VIII, IX and X), thyroid function (increase in PBI and butanol extractable protein-bound iodine and decrease in $T^3$ values), metapyrone test, pregnanediol determination.

Other side effects reported to have occurred in association with use of this drug are dizziness, hirsutism, pains in legs, back, chest and abdomen, dysuria, drowsiness, vaginal discharge, libido increased and decreased, eruptions, hypermenorrhea, hypomenorrhea, increased appetite, G.U. infections, varicose veins, abdominal fullness, acne, headache, nervousness, allergies, blurred vision, pain in eyes, and itching in eyes. *For complete clinical data, see package insert.*

**Dosage and Administration:** 1. One tablet of Norinyl-1 is administered orally for 20 days beginning on day 5 of the menstrual cycle. (Count day 1 of the cycle as the first day of menstrual bleeding.) Repeat this dosage schedule for each cycle. 2. If no menstrual period occurs after a cycle of treatment (20 tablets) in which patient adhered to the schedule, the patient must be instructed to resume taking the Norinyl-1 tablets 7 days after the previous 20-day course was completed. For example, if the last pill of a previous cycle had been taken on a Sunday, then a new cycle of treatment should begin on the following Sunday. 3. In the postpartum woman, it is recommended that the first cycle of treatment should begin on day 5 of the first menstrual cycle. However, Norinyl-1 should not be administered during lactation.

**Availability:** Norinyl-1 (norethindrone 1 mg. with mestranol 0.05 mg.)—Dispensers of 20 and 60 and bottles of 250 tablets.

norethindrone — an original steroid from

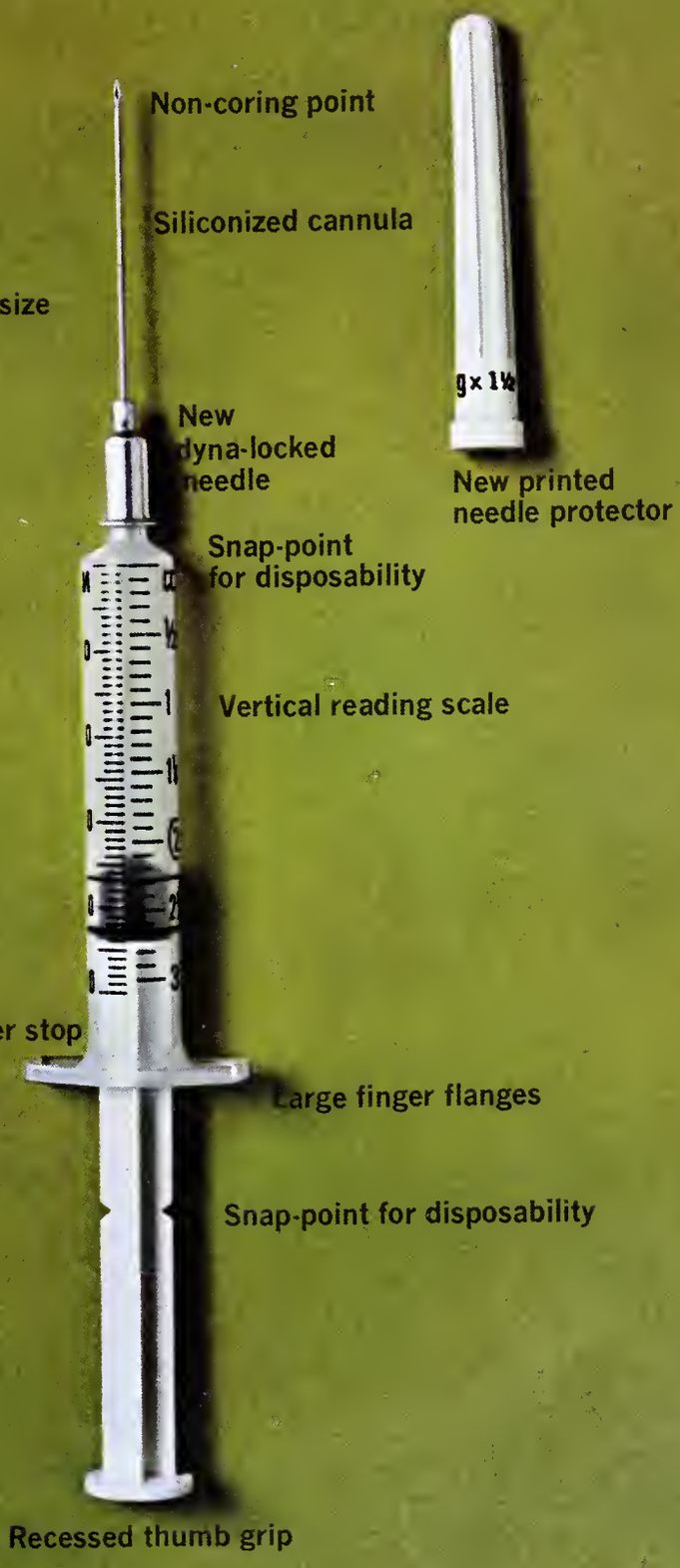
SYNTEX LABORATORIES INC., PALO ALTO, CALIF.

# Try this. Put your disposable syringe over this picture of our new 3 cc. size. Feature for feature, can yours match ours? Not likely. To try the real thing, write fo a sample of the new JELCO Disposable Syringe.

TRADEMARK

Air tight and waterproof package



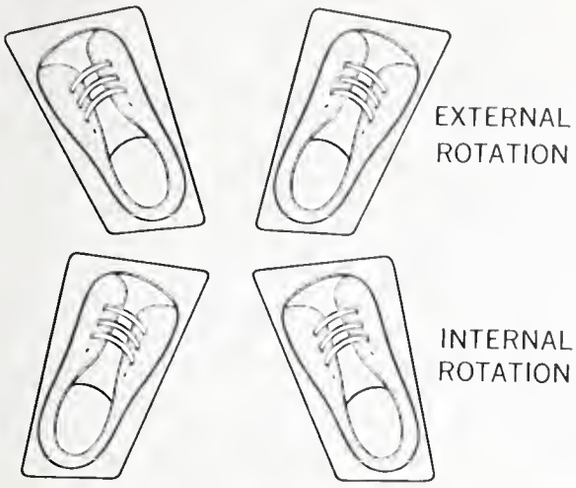




JELCO
LABORATORIES
RARITAN, N.J. 08869
a Johnson & Johnson Com

# Remember... JELCO I.V. Catheters have twistability!
# Unmatched flex life and tensile strength.
# Write for a JELCO TRADEMARK I.V. Catheter Placement Unit.
# Give it your own twist test.



JELCO
LABORATORIES
RARITAN, N.J. 08869
a Johnson & Johnson Company






# A new angle in the treatment of minor foot and leg abnormalities

For abnormal internal rotations and external rotations of hips, legs or in the lower extremities — also where shoes and bar were previously used.

MATLES ROTO-SLEEPER
SABEL'S
Patent Applied for

## ROTO-SLEEPER

**The angles of the plate maintain the same rotation of the leg, whether the child sleeps on its back, either side or prone.**

Sizes: Medium 000 to 12, full sizes only.

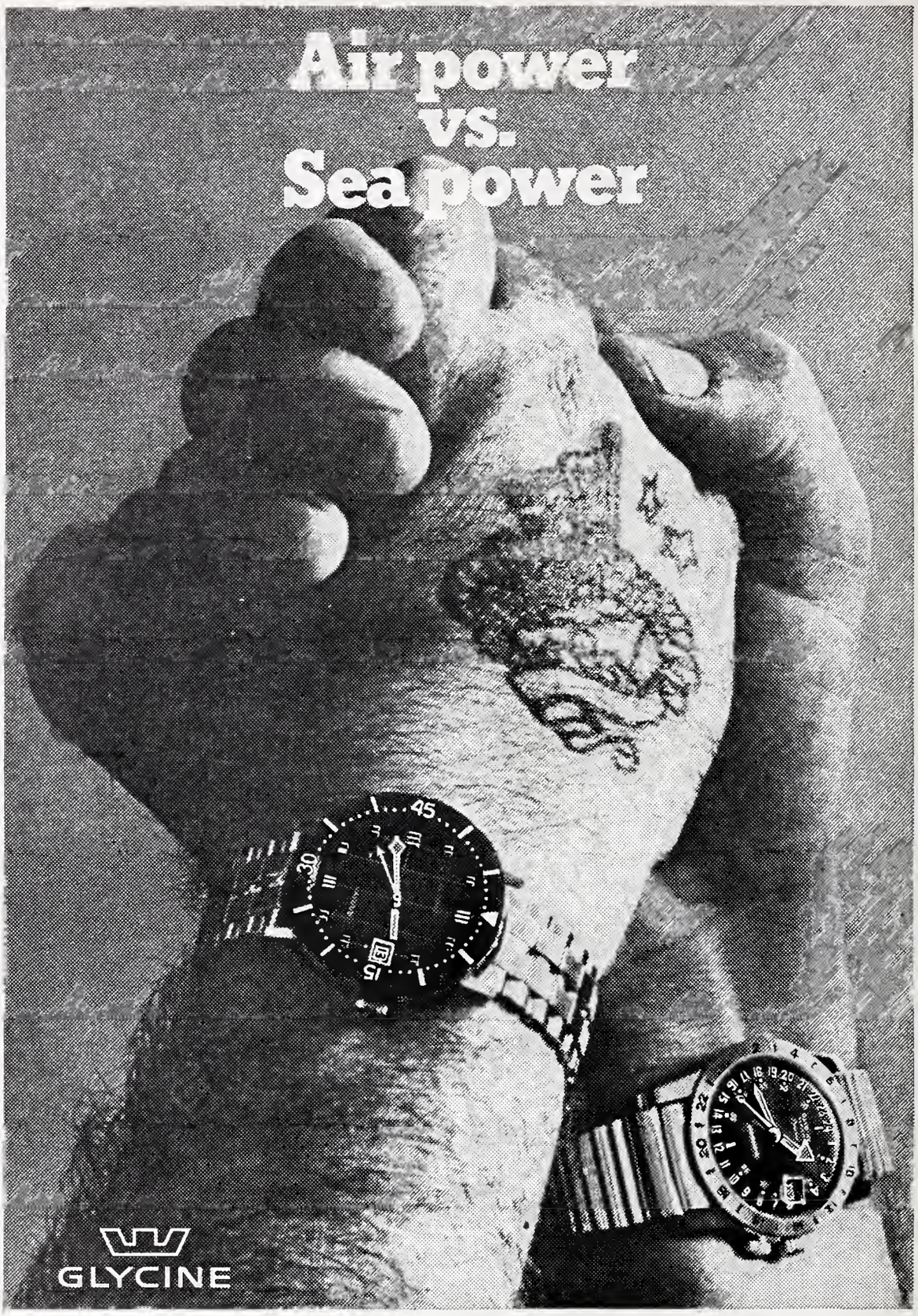
Order from your franchised Sabel dealer.
Sold only on a doctor's prescription.

*For Further Information or Demonstration*

call or write

**TEENY TOTS' FOOTWEAR**
Investors Finance Bldg.
1111 Bishop St. Tel. 586-163

*Authorized Sabel Representative in Hawaii*




**In this corner:**
The Glycine Skindiver. Self-winding. Calendar. 100% Water-proof* to 750 feet. Seventeen jewels. Stainless steel. Shock resistant. Revolving bezel shows elapsed time of dive. Vacuum sealed (moisture, condensation, corrosion and dust are locked out). $99.50

**In this corner:**
The Glycine Airman. Self-winding. Calendar. 24 hour dial and action. Seventeen jewels. Stainless steel. Shock resistant. Waterproof*. Hack feature allows setting to exact second. 24 hour locking bezel converts time to G. M. T. $100

*As long as case, crown and crystal are intact.

*"OVER 700 STORES TO SERVE YOU"*

DOWNTOWN
1045 BISHOP ST.

OPEN AN ACCOUNT
CONVENIENT TERMS

ZALE'S®
JEWELERS

KAILUA
KAILUA SHOPPING CENTER

AMERICA'S
LARGEST JEWELERS

# Any good hypoallergenic formula can protect the allergic child

## but now, there's more to the picture!





# Hypoallergenic ProSobee® protects and provides the extra benefits of these milk-like qualities:



**1. More natural stool patterns.** The stool patterns of infants on ProSobee formula resemble those of infants on milk-based formula. There is no offensive odor, no major variance in color, no tendency to looseness, and no unfamiliar staining of diapers. Nothing to alarm the mother... nothing to impel a "worry" telephone call.

**2. Natural appearance and consistency.** New, milk-like ProSobee formula makes the transition to a hypoallergenic nutritional less troublesome than ever before. There's no coffee color, no "beany" aroma. No nipple-clogging coarseness, either! ProSobee utilizes a new soy-protein isolate which eliminates the negative properties associated with most soybean formulas.

With ProSobee formula, feeding time remains a pleasant experience... uncomplicated by a mother's possible aversions (which may be communicated to the sensitive infant).

**3. And good nutrition, naturally!** The protein efficiency value of ProSobee formula closely approaches that of casein, and is higher than values found in whole soy flour formula. Further, in a recent study* (where the positive antigenicity of soy flour and two commercially available soybean infant formulas was shown), highly potent rabbit antisera produced *no precipitin bands* against ProSobee formula. It is truly hypoallergenic!

*Crawford, L. V., et al.: Ann. Allergy *23*:303 (July) 1965.

ProSobee is a trademark of Mead Johnson & Company. © 1966, M. J. & Co.

**ProSobee®**
MILK-FREE FORMULA WITH SOY ISOLATE

Mead Johnson
LABORATORIES

*Research for Life*



*"George wants to know if it's okay to take his cold medicine now, Doctor, instead of seven o'clock?"*



The long-continued action of Novahistine LP should help you both get a good night's sleep. Two tablets in the morning and two in the evening will usually provide round-the-clock relief by helping clear congested air passages for freer breathing. Novahistine LP also helps restore normal mucus secretion and ciliary activity—normal physiologic defenses against infection of the respiratory tract. Use cautiously in individuals with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result. Each Novahistine LP tablet contains: phenylephrine hydrochloride, 25 mg., and chlorpheniramine maleate, 4 mg.

# NOVAHISTINE® LP

DOW **PITMAN-MOORE** Division of The Dow Chemical Company, Indianapolis

even better together
in mild hypertension

# Serpasil®-Esidrix®

(reserpine and hydrochlorothiazide CIBA)
Combination Tablets



Serpasil-Esidrix combines reserpine (the original, and most widely used, rauwolfia alkaloid developed by CIBA) with hydrochlorothiazide (the most widely used oral diuretic, also a product of CIBA research).



## even better blood pressure reduction—because 2 antihypertensive agents of choice often work better together

One drug potentiates the antihypertensive action of the other. Blood pressure is generally controlled with relatively low dosages of each component, often resulting in minimized side effects.

Although each component alone may provide adequate therapy in many cases of mild hypertension, the combination offers advantages which cannot be achieved with single-drug therapy.



## even more patient benefits—because complementary actions of 2 antihypertensive agents extend the range of advantages

Reserpine, in addition to lowering blood pressure, provides central calming action to help relieve anxiety and tension; provides bradycrotic action to slow the rapid heart.

Hydrochlorothiazide, in addition to lowering blood pressure, relieves edema; permits relaxation of salt restriction.

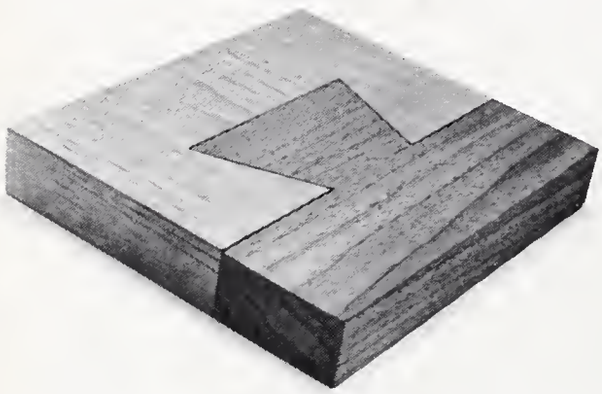
The combination provides medication in one tablet instead of two; one prescription instead of two—encourages patient adherence to the regimen, offers economy.

## for your next patient with mild hypertension

# Rx Serpasil-Esidrix Combination Tablets

Please see following page for prescribing information.

# Serpasil®-Esidrix®
## (reserpine and hydrochlorothiazide CIBA)
# Combination Tablets



INDICATIONS: Mild to moderate hypertension, especially when complicated by anxiety, tachycardia, or edema.

SIDE EFFECTS AND PRECAUTIONARY MEASURES

**Serpasil® (reserpine CIBA)**
Occasional side effects: lassitude, drowsiness, nasal congestion, looseness of stools, increased frequency of defecation. Rare side effects: anorexia, headache, bizarre dreams, nausea, dizziness, skin rash.

Severe mental depression has appeared in a small percentage of patients, primarily in a dosage above 1 mg daily. When the drug is discontinued, depression usually disappears, but hospitalization and shock therapy are sometimes required.

*Caution:* Withdraw reserpine 2 weeks before surgery, if possible. For emergency surgical procedures, give vagal blocking agents parenterally to prevent or reverse hypotension and/or bradycardia.

Because reserpine may increase gastric secretion of hydrochloric acid, use cautiously in patients with peptic ulcer.

Use cautiously with digitalis, quinidine, or guanethidine. Not recommended for aortic insufficiency.

**Esidrix® (hydrochlorothiazide CIBA)**
*Contraindictions:* Oliguria, renal shutdown, progressive hepatic disease, and allergy to thiazides.

*Warnings:* Stenosis, hemorrhage, and ulceration of the small bowel have occurred with coated potassium tablets. Discontinue such medication when used with Esidrix if gastrointestinal disturbances arise.

Pay special attention to electrolyte balance of patients with severe renal or hepatic insufficiency. In patients with cirrhosis and ascites, watch for symptoms of impending hepatic coma. Thiazides may decrease glucose tolerance; use cautiously in diabetics. Hyperuricemia may occur but is readily reversed by a uricosuric agent. Lowering of blood pressure may sometimes result in nitrogen retention, particularly in patients with impaired renal function. Dosage titration is necessary in such patients.

*Precautions:* Watch for signs of fluid or electrolyte imbalance. Further electrolyte depletion may cause hypochloremic alkalosis and hypokalemia. Since the latter may precipitate digitalis intoxication, watch carefully patients who are taking digitalis or its glycosides or those with cardiac arrhythmias. In severe hypokalemia, large oral or intravenous doses of potassium may be required.

A few infants born of mothers who received thiazides during pregnancy have shown bone marrow depression with thrombocytopenia. Hydrochlorothiazide decreases responsiveness to exogenous norepinephrine and increases responsiveness to tubocurarine. Hypotensive episodes under anesthesia have been observed in some patients receiving thiazides.

*Side Effects:* In addition to those above, nausea, anorexia, headache, restlessness, constipation, dizziness, paresthesias, fatigue, increased sweating, cramps in arms and legs, diarrhea, abdominal pain. Rare reactions: purpura with or without thrombocytopenia, skin rash, photosensitivity, urticaria. Sometimes associated with hydrochlorothiazide: leukopenia, agranulocytosis, aplastic anemia, pancreatitis, jaundice, necrotizing vasculitis.

DOSAGE
Average dosage is 2 *Tablets #2* daily. For patients requiring less hydrochlorothiazide, substitute *Tablets #1*. For maintenance, reduce dosage to lowest effective level. When necessary, more potent antihypertensive agents may be added gradually in reduced dosages.

SUPPLIED
*Tablets #2* (light orange), each containing 0.1 mg reserpine and 50 mg hydrochlorothiazide; bottles of 100 and 1000. *Tablets #1* (light orange), each containing 0.1 mg reserpine and 25 mg hydrochlorothiazide; bottles of 100 and 1000.

*Consult complete literature before prescribing.*

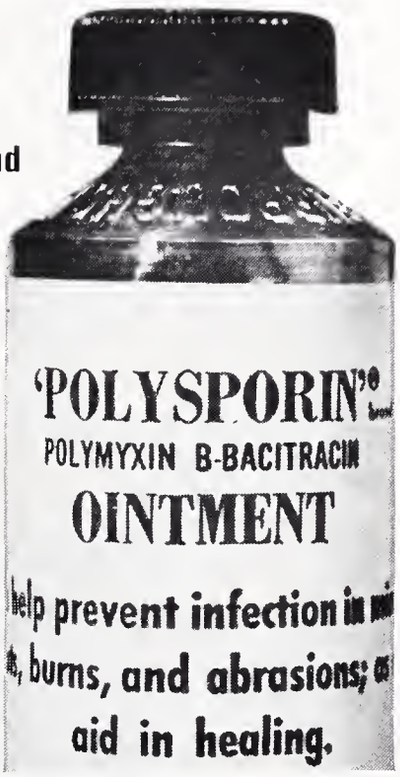
CIBA Pharmaceutical Company, Summit, N. J. C I B A

2/3595

*When the problem is only skin deep*

# USE 'POLYSPORIN'® brand POLYMYXIN B-BACITRACIN OINTMENT

**for topical antibiotic therapy with minimum risk of sensitization**

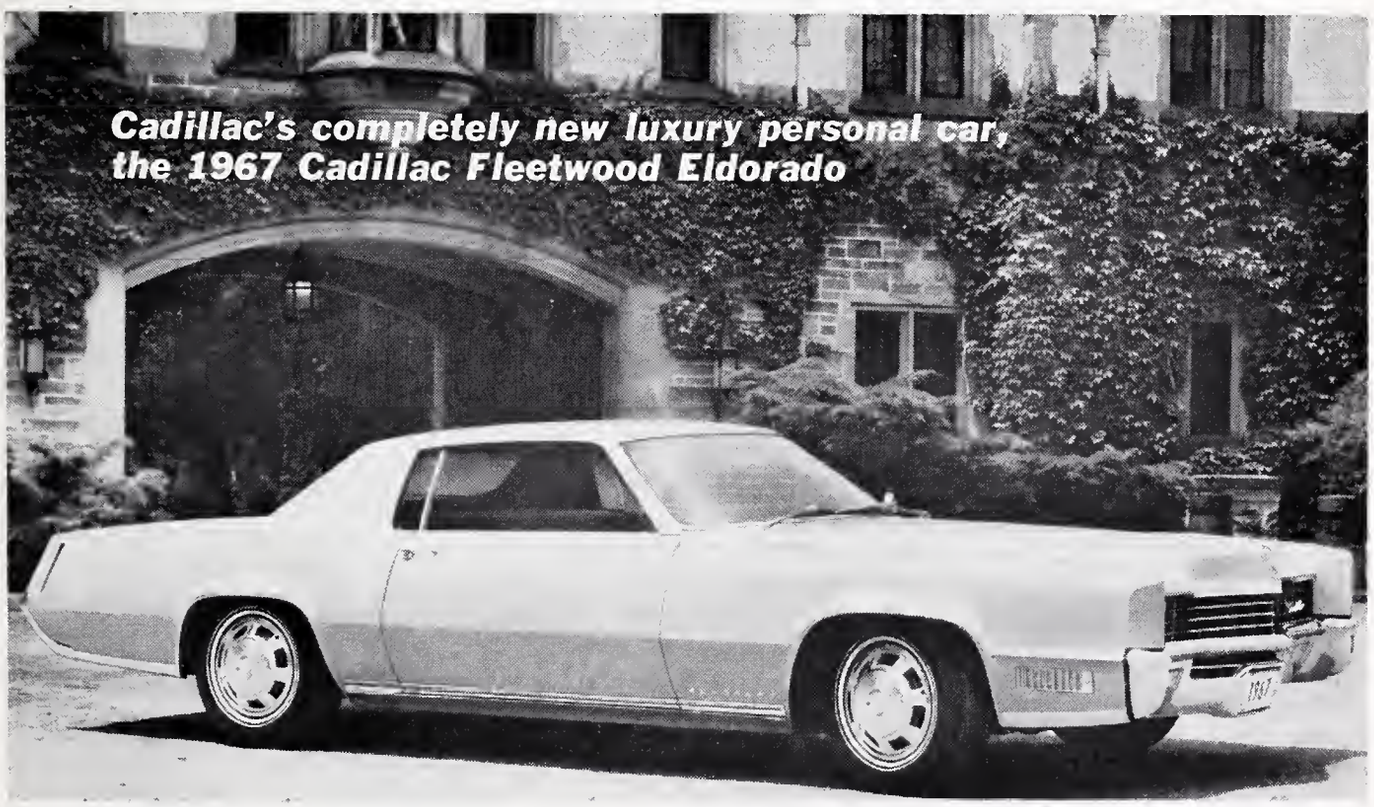



Caution: As with other antibiotic products, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

Supplied in ½ oz. and 1 oz. tubes.

Complete literature available on request from Professional Services Dept. PML.

BURROUGHS WELLCOME & CO. (U.S.A.) INC.
Tuckahoe, N.Y.




THE ONLY QUESTION THIS YEAR IS: WHICH CADILLAC?

*See all the exciting new Cadillac models at* **SCHUMAN'S**
*1234 South Beretania Street*

# Carnation

EVAPORATED MILK

## HAWAII'S HEALTHY BABY MILK...




*"from Contented Cows"*

***1st CHOICE FOR INFANT FEEDING...***
***No. 1 in the Islands for generations,***
***...available everywhere in Hawaii***



1966
Carnation Healthy Baby Contest
$1,000 1st prize winner,
Peter David Keaomalamalama Yoshimi Malo
of Honolulu, Hawaii

# Don't let monilia cut broad-spectrum therapy short...

## start with Tetrex-F®

## tetracycline phosphate complex-nystatin

Use of broad-spectrum antibiotics can cause fungal overgrowth in the alimentary tract... and give rise to symptoms so troublesome that therapy must be prematurely stopped. Tetrex-F (tetracycline phosphate complex-nystatin) helps you circumvent this problem.

The nystatin can prevent overgrowth of monilia; the phosphate complex delivers tetracycline to the blood rapidly. Side effects are infrequent.

**High-Risk Patients**

Tetrex-F (tetracycline phosphate complex-nystatin) is especially useful in patients most susceptible to fungal overgrowth during tetracycline therapy: (1) the elderly or debilitated, (2) young children, (3) the diabetic, (4) those on long-term tetracycline therapy, (5) those on steroid therapy, (6) those who have had moniliasis before, and (7) pregnant patients with a history of monilial vaginitis.

When you start with economical Tetrex-F (tetracycline phosphate complex-nystatin), you can complete the full course of broad-spectrum therapy with less chance of losing control elsewhere. A good start for a healthy finish.

PRESCRIBING INFORMATION. For complete information consult Official Package Circular. *Indications:* Infections of respiratory, gastrointestinal and genitourinary tracts and skin and soft tissues due to tetracycline-sensitive organisms, in patients with increased susceptibility to monilial infections. *Contraindications:* The drug is contraindicated in patients hypersensitive to its components. *Warnings:* Photodynamic reactions have been produced by tetracyclines. Natural and artificial sunlight should be avoided during therapy. Stop treatment if skin discomfort occurs. With renal impairment, systemic accumulation and hepatotoxicity may occur. In this situation, lower doses should be used. Tooth staining and enamel hypoplasia may be induced during tooth development (last trimester of pregnancy, neonatal period and childhood). *Precautions:* Bacterial superinfections may occur. Infants may develop increased intracranial pressure with bulging fontanels. In gonorrheal therapy, serologic tests for syphilis should be conducted initially and monthly for 3 months. *Adverse Reactions:* Glossitis, stomatitis, nausea, diarrhea, flatulence, proctitis, vaginitis, dermatitis, and allergic reactions may occur. *Usual Adult Dosage:* 1 capsule q.i.d. Continue for 10 days in Beta-hemolytic streptococcal infections. Administer one hour before or two hours after meals. *Supplied:* Capsules, bottles of 16 and 100. Each capsule contains tetracycline phosphate complex equivalent to 250 mg. tetracycline HCl activity and 250,000 units of nystatin. For Oral Suspension, 125 mg. tetracycline and 125,000 u. nystatin/5 ml., 60 ml. bottles.

BRISTOL

BRISTOL LABORATORIES
Division of Bristol-Myers Company
Syracuse, New York 13201


1 PINT (473 cc.) M-87
SUSPENSION
CO-PYRONIL
PYRROBUTAMINE COMPOUND
100 No. 336
PULVULES
CO-PYRONIL
PYRROBUTAMINE COMPOUND
000
Lilly
No. 342
PULVULES
CO-PYRONIL
PYRROBUTAMINE COMPOUND
Pediatric
Lilly
for
quick relief
that lasts
and lasts
Co-Pyronil®
Pyrrobutamine Compound
Additional information available to physicians upon request. ELI LILLY AND COMPANY, INDIANAPOLIS, INDIANA 46206.
Lilly
700607

# Presidential Address

THEODORE T. TOMITA, M.D., *Waipahu*

One year ago, when you installed me as President of this Association, you bestowed upon me a great honor. I pledged to you at the time that I would do my best to uphold the fine traditions of physicians in Hawaii. The measure of success attained was only possible because of the faithful support of my officers, commissioners, members of the Council, chairmen and members of all the 50-odd committees, and staff members. For their full measure of support I am deeply grateful.

## MEDICARE

Soon after I took office, Medicare, which had been vigorously opposed by the medical profession, became a reality on July 1, 1966. With it came various problems. One was that of the hospital-based specialists. The Federal agencies sought to classify them under Part A instead of under Part B of the law. This would have made the physicians' services a part of the hospital costs.

Failing to divide and conquer, the Federal government then brought suit against the pathologists, charging a monopoly on their part. While this act of intimidation is still unsettled, the Federal agencies now have proposed in Congress that a new section, called Part C, be made an amendment to Title XVIII. This would classify hospital-based specialists separately from other physicians.

The most serious problem posed by Medicare in Hawaii has been the separation of plantation physicians from their jobs for refusing to reimburse the plantation with that portion of Part B funds which rightfully belongs to the physicians.

This Association has repeatedly enunciated the Principles of Medical Ethics, the principle of free choice of physician, and the fee-for-service concept. We have held that the practice of medicine by a corporation is illegal in Hawaii. Our Legislative Committee had a bill introduced in the Senate during the last session which would have included in the Medical Practice Act a section specifically prohibiting a corporation from practicing medicine. The law governing incorporation of corporations already states that corporations for profit cannot be formed for the purpose of carrying on any profession.

Nevertheless, we should not be too dismayed. Eventually we will be able to have this law amended. Persistence will be required. As you will recall, it took us five years to have the Workmen's Compensation fee schedule and law amended.

Your organization also must be commended for having the Aetna Insurance Company appointed as our intermediary, instead of HMSA. Our deep appreciation goes to our representatives in Washington for interceding in our behalf.

## TITLE XIX

In Hawaii your Legislative Committee was farsighted and fortunate enough to get the 1965 Legislature to accept the concept of free choice of physician and fee for service for the care of the indigent and medically indigent. Because of fiscal difficulties faced by our Legislature, these principles apply at present only to those living in the rural areas of Oahu and on the neighbor islands. I want the audience to know that this program is only possible because we have agreed to subsidize medical services at 30 per cent and surgical services at 20 per cent. In urban Oahu this program is subsidized 100 per cent by the physicians.

Despite our generous subsidy, the Department of Social Services took unilateral action in imposing a formulary based on an archaic 1961 Oregon schedule. This concept—that cheaper drugs should be used for the indigent—is contrary to our basic medical beliefs—that no patient should be treated differently because of economic status. This concept is also contrary to the position of the Federal government that economics should not make second-class citizens.

We have informed DSS that our subsidies will terminate after June 30, 1967, and we have told them that while the patients may be indigent or medically indigent, the government is not. And we feel that eventually all indigents should have the privilege of free choice of physicians and hospital facilities. The DSS plans to eliminate the subsidy on July 1, 1967.

## DEPARTMENT OF HEALTH

The Department of Health has accepted our concept of a Relative Value Schedule and fee for service. This has been in use since 1962 for referrals made by its Crippled Children's Bureau. Beginning July 1, the conversion factor will be brought up to the same level as that used by other government agencies. Unfortunately, the Depart-

Read to the membership May 20, 1967.

ment has not yet agreed to the fee-for-service concept for the various clinics it conducts. The physicians who work in these clinics are being paid by the hour. We have asked that they look into this further. We believe that most of the patients seen in clinics could qualify under Title XIX.

The problems in the low-income areas are considered social rather than purely medical. A phrase to watch for in the next few years is one that was coined by L. B. J. in 1964 in a speech at Ann Arbor, Michigan. This term cropped up again only last Sunday when a Honolulu newspaper said the recent Pacific Conference on Urban growth was an "uneasy" example of creative federalism.

The medical profession has felt the impact of creative federalism. It is apparent from the editorial that creative federalism is a spreading virus. Watch for the effect of it upon professions other than medicine, as creative federalism begins to apply bureaucratic rigidity to the professions of law, engineering, and architecture.

The officers of the Department of Health have been cooperative and with further expansion of Federal Programs—such as PL 89-239 and PL 89-749 being delegated to the State level—it is my hope that this attitude of cooperative consultation will be further enlarged and preserved.

### WORKMEN'S COMPENSATION

On November 3, 1966, a public hearing was held in Honolulu on the Workmen's Compensation Fee Schedule. At this hearing the presentation was so well documented and well organized that the voice of organized medicine dominated the hearing: a reversal of five years of futile effort. The Director of Labor accepted our concept of RVS with a conversion factor of five and recommended its acceptance for the City & County of Honolulu.

To my dismay, despite the fact that we had testified for the State as a whole, the Director interpreted the law to mean that public hearings must be held separately in the three other counties. Therefore, Mr. Rice, our attorney, and I spent three separate nights on Maui, Hawaii, and Kauai. When the concept of the RVS was accepted, the inequities in fees in the radiology section, where the generalist was being paid only two-thirds of his regular fee, were eliminated.

In the meantime, the Director had recommended to the Legislature that this fee schedule should be applicable statewide, and so HB 552 was introduced in the Legislature. It passed both the House and the Senate, with minor amendments, and was signed into law by our Governor as Act 16.

Here again I must commend both your Workmen's Compensation Committee and Legislative Committee for a job well done in establishing good rapport with the various branches of government.

### UNIVERSITY OF HAWAII

About two years ago I was openly opposed to an establishment of a two-year medical school in our state. First, I firmly believed that we were an insular, agricultural community and that we would not be able to support a first-class medical school. Second, I believe our students should be educated outside of our State in order to broaden their horizons and to allow them to rub shoulders with students of outstanding quality from all over the country and the world. Thirdly, I felt that it would be cheaper and more rewarding to have students graduate from already well-established medical schools, even if the State had to subsidize the entire four years of medical training.

Now that this medical school is a reality, however, I believe we, as practicing physicians, cannot afford to let the town-and-gown feeling develop. We should encourage a closer liaison with the University medical faculty to the end that the school will become one of the best two-year medical schools in the U.S.

I feel that an even greater future will be assured when the University adds a four-year medical school and becomes a center of excellence in research, quality medical care, and continuing medical education. Then it will be famous not only in Hawaii, but in the whole Pacific Basin—in fact, in the whole world.

### HMSA

For the younger physicians who are not familiar with the history of HMSA, I should like to quickly review the trend of events which led to our impasse with HMSA. HMSA was founded as a tax-free organization by the people of Hawaii, with the cooperation of the physicians, to aid the low-income people to meet their medical obligations.

HMSA gradually included more and more groups and became a huge monopoly, all the while being subsidized by the physicians at discounted fees.

In spite of our plea that HMSA, as a tax-free organization, should be offering the people of Hawaii more comprehensive coverage with predictability of costs, they repeatedly refused to meet this challenge.

They have acted unilaterally on many occasions when the occasion suited their needs, and only sought to divide and conquer the physicians and to subjugate us to the point of embarrassment and humility.

Their arrogance has brought upon them the wrath of the legislators, and the financial and operative structures of the organization were, and

*continued page 628*

*Dysproteinemias involving immunogobulins G and A are the same in Hawaii as elsewhere, apparently.*

# Multiple Myeloma and Macroglobulinemia Cases in Hawaii*

WILLIAM HARTMAN, B.S.,† REMEDIOS FARIN, B.S., and MITSUO YOKOYAMA, M.D., *Honolulu*

• *The serum immunoglobulin levels are elevated in multiple myeloma, due to the rapid proliferation of plasma cells. Zone electrophoresis reveals a relatively homogeneous globulin pattern, as compared to the normal heterogeneous serum gamma globulin pattern. There is a decrease in the level of normal gamma globulin, corresponding to the increase in the myeloma protein level.*

SERA OF INDIVIDUALS with conditions involving an unusual elevation of gamma globulin levels were obtained from hospitals and clinics in Honolulu and other parts of Hawaii. The sera were kept frozen at –20° C. prior to use.

Zone electrophoretic studies were carried out in agar gel,[1] using glass slides coated with 1.5% Noble agar solution in 0.05M barbital buffer, pH 8.6. The slides were previously precoated with 0.5% aqueous agar and dried for 30 minutes at 100° C. A well was cut into the agar gel after it had solidified and approximately 0.01 ml of serum was introduced into the well. The slide was placed in an electrode vessel containing barbital buffer, pH 8.6, ionic strength 0.05, and 3 mA/cm were applied for electrophoresis for two hours. Whatman 3MM filter paper was used as wicks connecting the agar gel and the buffer. The electrophoretic pattern was fixed in 3% acetic acid solution for 30 minutes, stained with 1% Buffalo-blue-black solution after the slide had been washed with distilled water, and dried by covering with filter paper and letting stand at room temperature.

Agar-gel slides for the immunoelectrophoretic studies[2] were prepared in the same manner as for the zone electrophoretic studies. In addition, a 6 cm trough was cut 8 mm from the well, on both sides of the well, and parallel to the intended line of migration. Electrophoresis was carried out as in the above method; however, the pattern was not fixed. After completion of the electrophoretic separation, antihuman serum, prepared at the Kuakini Research Foundation laboratories, was introduced into each trough and the slide was allowed to stand for 24 hours in a humid chamber. The immunoprecipitin pattern was stained with 1% Buffalo-blue-black after the slide had been successively washed with 0.15M NaCl solution and distilled water, then dried at room temperature.

The modified Smithies' method[3] was employed in the starch-gel electrophoretic studies. The hydrolyzed starch powder used in this study was obtained from the Connaught Medical Research Laboratories of the University of Toronto. A 12.5% starch solution in 0.021M $H_3BO_3$ –0.0084M NaOH buffer was prepared and the solution was then heated with agitation until a transparent, viscous liquid was obtained. Following removal of the air bubbles by suction, the

* This work was supported by the Memorial Fund for Mrs. Lois A. Mayers.
† Student at Washington and Lee University, Lexington, Virginia, and grantee of the Kuakini Research Foundation.‡
‡ Presently Kuakini Medical Research Institute.

TABLE 1. *Multiple Myeloma Cases*

| PATIENT | SEX | AGE | ETHNIC ORIGIN | TYPE OF GLOBULIN | CRYO-GLOBULIN | SIA TEST | | BLOOD GROUP | ISOAGGLUTININ TITER | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | R.T.† | | COLD‡ | |
| | | | | | | *Floc.** | *Reppt.*** | | *Anti-A* | *Anti-B* | *Anti-A* | *Anti-B* |
| 1. | F | 62 | Haw./ Port. | $IgG_1$ | Neg. | Neg. | Neg. | O | 1:64 | 1:16 | 1:128 | 1:16 |
| 2. | M | 74 | Malayan | $IgG_1$ | Neg. | Neg. | Neg. | A | 0 | 1:32 | 0 | 1:32 |
| 3. | M | 40 | Haw. | $IgG_1$ | Neg. | Pos. | Neg. | B | 1:16 | 0 | 1:32 | 0 |
| 4. | M | 67 | Haw. | $IgG_2$ | Neg. | Pos. | Neg. | AB | 0 | 0 | 0 | 0 |
| 5. | F | 66 | Jap. | $IgG_2$ | Neg. | Neg. | Neg. | B | 1:8 | 0 | 1:8 | 0 |
| 6. | F | 38 | Haw. | $IgG_2$ | Pos. | Pos. | Neg. | O | 1:64 | 1:8 | 1:64 | 1:8 |
| 7. | M | 56 | Chin. | $IgG_2$ | Neg. | Pos. | Neg. | O | 1:8 | 1:64 | 1:8 | 1.64 |
| 8. | M | 73 | Filp. | $IgG_2$ | Neg. | Pos. | Neg. | O | 1:16 | 1:8 | 1:16 | 1:16 |
| 9. | F | 42 | Haw./ Chi./Cau. | $IgG_2$ | Neg. | Neg. | Neg. | O | 1:16 | 1:8 | 1:32 | 1:32 |
| 10. | F | 74 | Jap. | $IgG_2$ | Neg. | Pos. | Neg. | AB | 0 | 0 | 0 | 0 |
| 11. | F | 64 | Jap. | $IgG_2$ | Pos. | Pos. | Neg. | A | 0 | 1:8 | 0 | 1:8 |
| 12. | M | 56 | Jap. | $IgG_2$ | Neg. | Pos. | Neg. | B | 1:32 | 0 | 1:32 | 0 |
| 13. | F | 58 | Cau. | $IgG_2$ | Pos. | Pos. | Neg. | A | 0 | 1:8 | 0 | 1:8 |
| 14. | M | 60 | Jap. | $IgG_2$ | Neg. | Neg. | Neg. | AB | 0 | 0 | 0 | 0 |
| 15. | M | 49 | Jap. | $IgG_2$ | Neg. | Neg. | Neg. | O | 1:32 | 1:8 | 1:32 | 1:8 |
| 16. | F | 68 | Jap. | $IgG_2$ | Pos. | Pos. | Neg. | A | 0 | 1:16 | 0 | 1:16 |
| 17. | F | 59 | Port. | $IgG_2$ | Neg. | Pos. | Neg. | O | 1:256 | 1:128 | 1:512 | 1:256 |
| 18. | F | 43 | Jap. | $IgG_2$ | Neg. | Neg. | Neg. | B | 1:4 | 0 | 1:8 | 0 |
| 19. | M | 56 | Chin. | $IgG_3$ | Neg. | Pos. | Neg. | O | 1:16 | 1:4 | 1:16 | 1:4 |
| 20. | F | 37 | Cau. | IgA | Neg. | Pos. | Neg. | O | 1:4 | 1:4 | 1:4 | 1:4 |
| 21. | M | 70 | Cau. | IgA | Pos. | Pos. | Neg. | A | 0 | 1:16 | 0 | 1:16 |
| 22. | F | 60 | Span./ P.R. | IgA | Pos. | Pos. | Neg. | B | 1:16 | 0 | 1:16 | 0 |
| 23. | M | 45 | Jap. | IgA | Pos. | Pos. | Neg. | AB | 0 | 0 | 0 | 0 |
| 24. | M | 62 | Haw. | IgA | Pos. | Pos. | Neg. | A | 0 | 1:4 | 0 | 1:4 |
| 25. | M | 48 | Jap. | IgA | Neg. | Neg. | Neg. | O | 1:8 | 1:32 | 1:16 | 1:32 |
| 26. | M | 62 | Cau. | IgA | Pos. | Neg. | Neg. | B | 1:2 | 0 | 1:2 | 0 |

* Flocculation test
** Reprecipitation test
† At room temperature (25° C.)
‡ At refrigerated temperature (5° C.)

starch was immediately poured into a 196 × 84 × 4 mm plastic mold and allowed to solidify for two hours. The serum sample was introduced into the gel by inserting a piece of filter paper, 3 × 5 mm, saturated with the serum, into a small slit in the gel made with a razor blade. The electrode vessel contained 0.3M $H_3BO_3$ with 0.06M NaOH buffer and Whatman 3MM filter paper was used for wicks. Electrophoresis was effected at 400 volts for three hours at a constant cold temperature. After the migration was completed, the starch was removed from the mold and stained with 0.5% Nigrosin for 10 minutes, then destained with a solution of water, methanol, and acetic acid in a 1:1:0.4 ratio.

Electrophoresis of the sera on cellulose-acetate strips (Beckman) was also performed. The acetate strips, soaked in barbital buffer, pH 8.6, were placed in a Durrum-type Spinco electrophoresis cell containing the barbital buffer and approximately 0.003–0.005 ml of the serum samples were applied onto the surface of the strips, using a narrow loop made of very fine wire, designed and constructed by this laboratory. Filter paper wicks (Whatman 3MM) were used to connect the strips and the buffer.

For cryoglobulin determination, the serum was separated from the clot at 37° C. and was allowed to stand at 5° C. overnight. The presence of cold-precipitable serum globulin was marked by the appearance of a precipitate, which increased in concentration upon prolonged incubation.

The samples were next subjected to the Sia test for abnormal macroglobulin, as described by Jim[4]. One part of serum was added to 16 parts of cold de-ionized water, previously adjusted to pH 6.4. In Waldenström's macroglobulinemia a flocculent white precipitate is formed within 10 seconds and settles rapidly to the bottom of the tube (flocculation test). Addition of normal saline will dissolve the precipitate and addition of more de-ionized water will cause reprecipitation (reprecipitation test).

The isoagglutinin titers of the sera were determined, using 2% suspensions of fresh normal human group A and group B erythrocytes in normal saline. The sera to be titrated were serially diluted with saline, in duplicate, and equal volumes of the group A erythrocyte suspension were added to one set and of the group B erythrocyte suspension to the other set. The mixtures were allowed to stand for 30 minutes at room temperature (25° C.), after which they were centrifuged for 1 minute at 1,000 rpm and the agglutination read macroscopically. The titration was also carried out at 4° C.

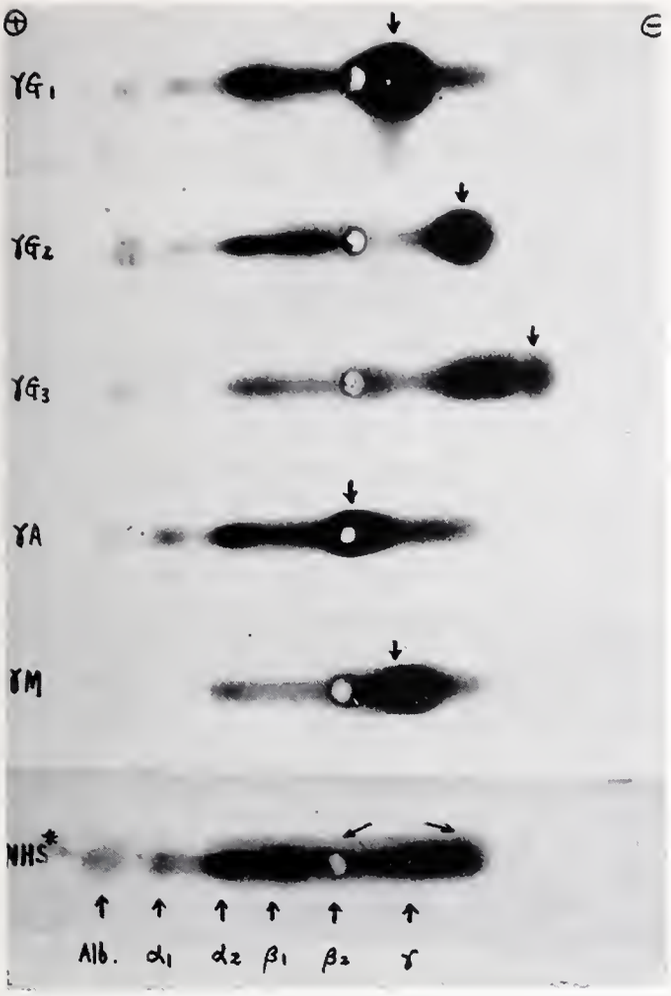



FIG. 1. *Electrophoretic patterns of sera in agar gel.*
* *Normal human serum.*

mas have been subdivided into three groups, depending on their electrophoretic mobility. The one having the faster-moving protein has been designated $IgG_1$ and that having the slower-moving protein, $IgG_3$. Gamma G myeloma having a protein of intermediate mobility has been designated $IgG_2$. The agar gel electrophoretic patterns of the IgA myeloma sera show an electrophoretically homogeneous protein mass of relatively fast mobility in the gammaglobulin region, appearing as a very dense spot located near the origin and extending through the beta region. The macroglobulinemia sera are characterized by dense, heavy, homogeneous protein masses extending from the points of application into the gamma globulin regions.

Immunoelectrophoretic patterns (Figure 2) of IgG myeloma show a localized increase and deflection of the IgG line in the specific area of migration of the protein. In the cases of $IgG_1$ myeloma, the increase is seen to be supplemental to the normal pattern of IgG, while some of the $IgG_2$ myeloma sera and the $IgG_3$ myeloma serum show an increase and deflection of the primary

AGE, SEX AND RACE

Table 1 shows that the 26 multiple myeloma patients ranged in age from 37 to 74 years with an average of 57 years. Of these, 54 percent were male and 46 percent were female. The ethnic distribution was: ten Japanese, six Hawaiian or part Hawaiian, four Caucasian, two Chinese, two Filipino, one Portuguese, and one Spanish–Puerto Rican. The age range of the macroglobulinemia patients was 66 to 88 years with an average of 74 years (Table 2). Of the six macroglobulinemia patients, there were two Caucasians, two Hawaiians, one Filipino and one Portuguese. Four of the patients with macroglobulinemia were male and two were female.

Figure 1 shows that the zone electrophoretic pattern of IgG* myeloma in agar gel characterizes it as a homogeneous protein mass of variable electrophoretic mobility. This protein varies from very slow, locating near the cathode in the gamma region, to much faster mobility, locating near the origin in the beta region. Hence, the IgG myelo-

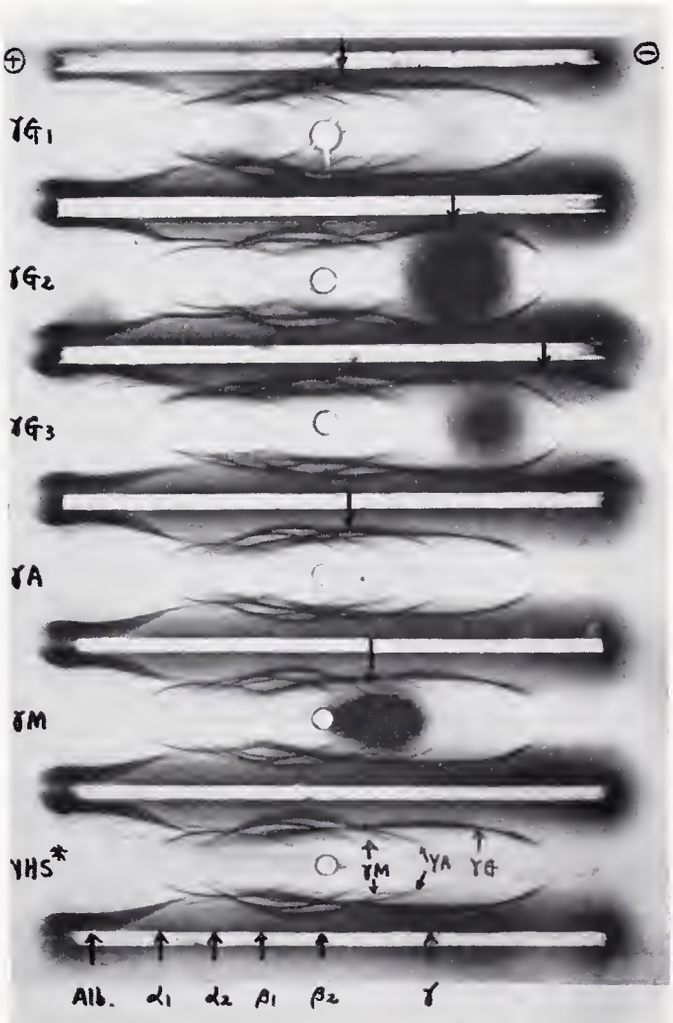



FIG. 2. *Immunophoretic patterns of sera in agar gel.*
* *Normal human serum.*

* IgG; new notation for immunoglobulin (formerly "gamma" globulin) G.

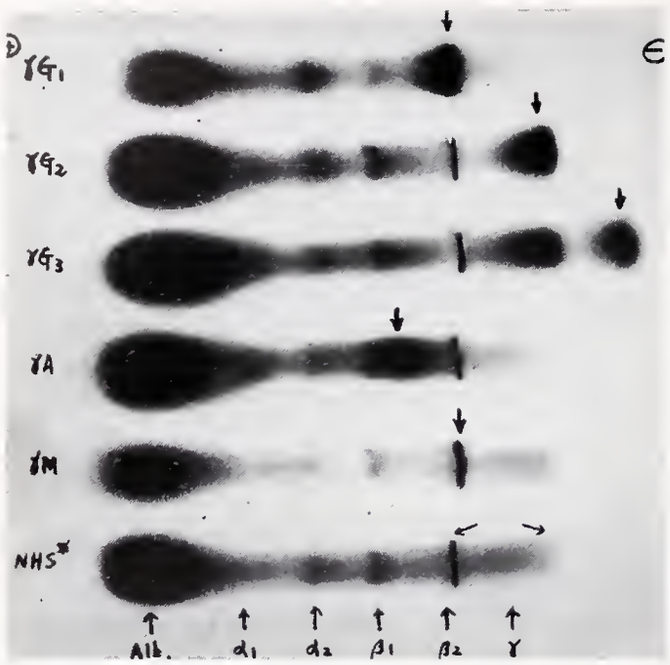



FIG. 3. *Electrophoretic pattern of sera in starch gel. * Normal human serum.*

IgG band. In IgA myeloma an increase in density and deflection of the IgA precipitin line, occurring near the point of origin and extending towards the anode, was revealed by immunoelectrophoresis. The precipitin arc intersects the normal IgG line. The immunoelectrophoretic pattern of Waldenström's macroglobulinemia sera showed a heavy IgM precipitin line. Much nondiffused protein remains in the agar during the washing and staining process, due to the size of the molecule.

The starch gel electrophoretic patterns (Figure 3) of the IgG myeloma cases were similar to their zone electrophoretic patterns in agar gel. The $IgG_1$ myeloma protein showed the fastest migration and the $IgG_2$ myeloma protein displayed a slower mobility, lying cathodal to the point of origin; the $IgG_3$ myeloma sera showed very slow migration of proteins. A heavy concentration of protein, which showed a high rate of migration towards the anode from the point of origin, characterized the IgA myeloma sera. The IgM macroglobulinemia sera, on the other hand, showed no migration of the fraction from the point of origin. This is due to the fact that the macroglobulin is too large to move through the starch gel and, therefore, remains at the origin.

Figure 4 shows that a pattern similar to that of starch gel electrophoresis was observed upon electrophoresis with cellulose acetate strips.

The incidence of cryoglobulin was found to be higher among IgA myeloma sera (5 out of 7) than among IgG myeloma sera (4 out of 19), and 5 out of 6 of the macroglobulinemia sera were positive for cryoglobulin. Twelve out of 19 of the IgG myeloma sera, 5 out of 7 of the IgA myeloma sera, and all of the macroglobulinemia sera gave positive Sia flocculation tests (Tables 1 and 2). However, only with the macroglobulinemia sera could the precipitin formed in the Sia test be dissolved with normal saline and reprecipitated upon the addition of distilled water; no reprecipitation occurred with the myeloma sera. The results of the cryoglobulin tests of all sera were shown to correlate closely with those noted in the Sia flocculation test and the results of the Sia reprecipitation test and the cryoglobulin test of the macroglobulinemia sera were identical.

In general, very low isoagglutinin titers were noted, despite the elevated immunoglobulin levels (Tables 1 and 2). Most of the titers were at the lower end of the normal range or below the normal level, which was shown to be between 1:16 and 1:128 for both anti-A and anti-B upon testing of 200 samples taken at random in the Honolulu area. It was noted that the isoagglutinin level

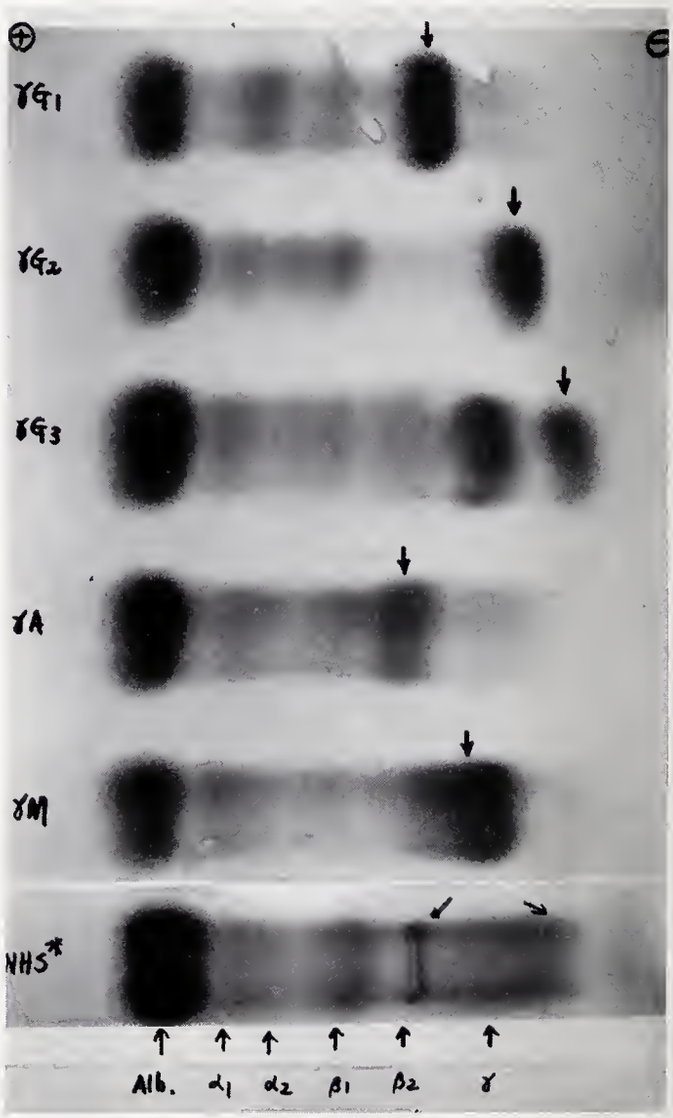



FIG. 4. *Electrophoretic patterns of sera on cellulose acetate strips. * Normal human serum.*

TABLE 2.—*Macroglobulinemia Cases*

| PATIENT | SEX | AGE | ORIGIN ETHNIC | TYPE OF GLOBULIN | CRYO-GLOBULIN | SIA TEST | | BLOOD GROUP | ISOAGGLUTININ TITER | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | *Floc.** | *Reppt.*** | | R.T.† | | COLD‡ | |
| | | | | | | | | | *Anti-A* | *Anti-B* | *Anti-A* | *Anti-B* |
| 1. | M | 72 | Cau. | IgM | Neg. | Pos. | Neg. | O | 1:2 | 1:8 | 1:2 | 1:8 |
| 2. | M | 66 | Cau. | IgM | Pos. | Pos. | Pos. | A | 0 | 1:4 | 0 | 1:4 |
| 3. | M | 65 | Filp. | IgM | Pos. | Pos. | Pos. | AB | 0 | 0 | 0 | 0 |
| 4. | M | 60 | Port. | IgM | Pos. | Pos. | Pos. | O | 1:256 | 1:32 | 1:256 | 1:128 |
| 5. | F | 88 | Haw. | IgM | Pos. | Pos. | Pos. | A | 0 | 1:8 | 0 | 1:16 |
| 6. | F | 70 | Haw./ Chin. | IgM | Pos. | Pos. | Pos. | A | 0 | 1:8 | 0 | 1:8 |

* Flocculation test
** Reprecipitation test
† At room temperature (25° C.)
‡ At refrigerated temperature (5° C.)

of myeloma sera was reflected by the presence of the normal IgG precipitin line along with the myeloma pattern in immunoelectrophoresis.

## DISCUSSION

One of the most characteristic clinical manifestations of multiple myeloma is bone pain with the frequent occurrence of spontaneous fractures. In addition, weakness, chills, and other manifestations of malignancy are frequently seen. Electrophoretic studies on multiple myeloma sera, using paper and cellulose-acetate strips, showed markedly elevated gamma globulin levels, and bone marrow studies revealed a proliferation of plasma cells.

In macroglobulinemia, however, bone and joint complaints are uncommon and spontaneous fractures are extremely rare. The symptoms are not specific, general malaise usually being reported. Anemia is also a frequent manifestation and the clinical picture is often dominated or influenced by hemorrhagic diathesis. Macroglobulinemia is often indicated by the presence of rouleau formation, accompanied by a nonspecific autoagglutination of the patient's own red cells in the cold, and a highly viscous appearance of the serum. The serum gamma globulin showed a high peak near the origin on electrophoretic strips and an increase in the number of plasma cells was noted in the bone marrow.

Among the present interests of this study is the distribution of patients with these diseases according to sex, age and race. The results found for cases in Hawaii were similar to figures reported from other geographic locations. The average age of myeloma patients is fifty-five. while macroglobulinemia patients, average seventy-five. Myeloma affects males and females about equally, while macroglobulinemia occurs among males twice as often as females. No significance can be drawn from the ethnic distribution, since all ethnic groups were not equally sampled.

Myeloma proteins of the IgG type are subdivided into three groups depending on their electrophoretic mobility in agar gel, starch gel and on cellulose acetate strips. $IgG_1$ is the fastest moving component, followed by $IgG_2$ and $IgG_3$ respectively. Seventy-three percent of the IgG myeloma cases studied were of the $IgG_2$ type.

Cryoglobulins are thermoproteins, a class of paraproteins which are demonstrable at cold temperatures and are commonly found in large quantities in multiple myeloma. The cold-sensitive proteins are also associated with chronic lymphocytic leukemia, lymphosarcoma, Kala-azar, systemic lupus erythematosus, rheumatoid arthritis, polycythemia vera, periarteritis nodosa, Sjögren's syndrome, subacute bacterial endocarditis, coronary artery disease, portal cirrhosis, and malignant tumors. In this study, cryoglobulin was found in 21% of the IgG myeloma sera, 71% of the IgA myeloma sera, and 83% of the macroglobulinemia sera.

The Sia reprecipitation test, as described by Jim[4], was shown to be more specific for the macroglobulin than for the myeloma protein. The formation of a floccule or moderate precipitate within 10 seconds is considered to be positive. The present study suggests that the second part of this test (reprecipitation), which involves dissolution of the precipitate by the addition of saline and reprecipitation upon the addition of distilled water, represents a dependable method for the specific identification of Waldenström's macroglobulinemia.

The results of the cryoglobulin test in IgA myeloma and macroglobulinemia sera showed greater correlation with the results of the Sia flocculation test than did the IgG myeloma sera. These results suggest that the cold precipitable and Sia flocculable euglobulin in IgA myeloma and macroglobulinemia sera are similar in molecular nature, while the IgA euglobulin is not.

Pyroglobulin, a heat-coagulable protein, was not demonstrated in the present cases; however, two cases of pyroglobulinemia were found in the sera of patients without myeloma and macroglobulinemia. Immunochemical studies on pyroglobulins in these cases, in addition to clinical observations, will be published in a later issue of the JOURNAL.

In general, patients with multiple myeloma or macroglobulinemia are particularly susceptible to bacterial infection and have been shown to have an impaired primary circulating antibody response, but the secondary response is normal. Hyperproteinemia occurs in the majority of these cases, as defined by total serum protein concentration. In some cases the total serum protein may be within normal limits, although characteristic abnormal spikes, exhibiting a single homogeneous peak in the gammaglobulin region, can be observed electrophoretically. This results in the production of large quantities of homogeneous gammaglobulins stemming from a plasma cell dyscrasia from a single cell or single group of plasmacytes (monoclonal proliferation). The abnormal proteins appear to be physically, chemically, and immunologically different from individual normal gamma globulins. The present results also demonstrated that there is no relationship in these diseases between the gammaglobulin concentrations and the isoagglutinin titers, which, in most of the patients' sera, were found to be significantly below the normal levels. Therefore, as previously stated,[5] it can be assumed that the abnormal gamma globulins may be immunologically inactive gamma globulins produced by neoplastic plasma cells.

## SUMMARY

Nineteen cases of IgG myeloma, seven cases of IgA myeloma and six cases of macroglobulinemia were found in Hawaii over the period from July 1964 to July 1966. Age, sex, and ethnic descent of the individuals having these diseases, which are felt to be neoplastic, were statistically observed; no differences were noted on comparison of the present data with previous reports. Low isoagglutinin titers were noted in most cases; however, these correlated with the presence of a residue of the normal IgG precipitin line, which appeared along with the myeloma arc in immunoelectrophoresis. ■

## REFERENCES

1. Yokoyama, M. and Carr, M.: Two dimensional immunoelectrophoresis in agar, Jap. J. Biol. Med. 15:1-6 (Jan.) 1962.
2. Scheidegger, J. J.: Une micro-méthode de l'immunoelectrophoresies, Lat. Arch. Allergy Appl. Immunol. 7:103-110 (Mar.) 1955.
3. Smithies, O.: Zone electrophoresis in starch-gels; group variations in the serum proteins of normal human adults, Biochem. J. 61:629-641 (Dec.) 1955.
4. Jim, R. T. S.: The Sia test, Kuakini Medical Bulletin 1:84-87 (June-Aug.) 1965.
5. Yokoyama, M., Stegmaier, A., Gilbert, F. I., Fukunaga, F. H., and Paik, Y. K.: Studies of blood groups, immunoglobulins and isoagglutinins in multiple myeloma and various hematological disorders in the Honolulu area, Hawaii Med. Jour. 25:106-111 (Nov.-Dec.) 1965.

*Highest age-corrected death rates in 19th century Honolulu were experienced not by the Hawaiians, but by the Japanese.*

# Differential Mortality in Honolulu Before 1900

ROBERT C. SCHMITT, M.A.,* *Honolulu*

• *The high mortality among Hawaiians in 19th-century Honolulu elicited a great deal of sympathetic attention then; it still does. For various reasons, we have failed to realize that mortality during this period was almost twice as high among the Japanese as among the Hawaiians and part-Hawaiians. The age-corrected rate of mortality among Portuguese and Chinese was about one-third that of the Japanese. Lowest was among the British and Americans. Highest of all was probably that among the South Sea Islanders, but their numbers were too few to permit valid comparisons.*

HAWAIIANS were dying in great numbers during the 19th century, causing serious concern among community leaders and triggering countless sermons, speeches, articles, and tracts addressed to this tragic depopulation. A similar wastage of human life, often involving appallingly high mortality rates, was taking place during the same period among a number of Hawaii's immigrant peoples. The plight of the foreigner, oddly, passed almost unnoticed. Even today, few persons seem aware of the death-filled history of the non-Hawaiians in the years following their arrival.

Evidence of these immigrant losses appears in Honolulu death rates for the period from 1878 to 1899. Unfortunately, systematic computation of such rates was not undertaken until the closing years of the century, when their diminishing severity lessened their impact. So far as can be

* State Statistician, Department of Planning and Economic Development, State of Hawaii.

Received for publication January 10, 1967.

TABLE 1.—*Deaths occurring in Honolulu, by Nationality: 1878 to 1899*

| YEAR[1] | ALL GROUPS | HAWAIIAN[2] | AMERICAN | BRITISH | PORTUGUESE | CHINESE | JAPANESE[3] | S. SEA ISLANDERS[4] | OTHER GROUPS[3] |
|---|---|---|---|---|---|---|---|---|---|
| 1878 | 638 | 543 | 13 | 18 | 5 | 46 | 2 | 1 | 10 |
| 1879 | 745 | 550 | 27 | 25 | 18 | 81 | .... | 24 | 20 |
| 1880 | 704 | 537 | 22 | 21 | 12 | 63 | 1 | 33 | 15 |
| 1881 | 651 | 486 | 20 | 20 | 15 | 84 | 1 | 12 | 13 |
| 1882 | 562 | 428 | 16 | 16 | 13 | 62 | .... | 10 | 17 |
| 1883 | 650 | 402 | 21 | 20 | 30 | 134 | .... | 13 | 30 |
| 1884 | 551 | 372 | 29 | 19 | 33 | 76 | .... | 5 | 17 |
| 1885 | 573 | 393 | 15 | 17 | 20 | 93 | .... | 7 | 28 |
| 1886 | 593 | 366 | 26 | 21 | 43 | 99 | 17 | 3 | 18 |
| 1887 | 555 | 376 | 23 | 17 | 31 | 67 | 12 | 12 | 17 |
| 1888 | 548 | 348 | 21 | 17 | 37 | 101 | 8 | 16 | |
| 1889 | 627 | 407 | 19 | 16 | 60 | 77 | 21 | 27 | |
| 1890 | 652 | 426 | 23 | 23 | 50 | 83 | 21 | 26 | |
| 1891 | 701 | 434 | 29 | 19 | 67 | 92 | 39 | 21 | |
| 1892 | 555 | 324 | 21 | 22 | 44 | 97 | 28 | 19 | |
| 1893 | 617 | 370 | 16 | 16 | 52 | 102 | 44 | 17 | |
| 1894[5] | 474 | 254 | 26 | 13 | 43 | 87 | 34 | 17 | |
| 1895 | 731 | 431 | 34 | 24 | 57 | 115 | 48 | 22 | |
| 1896 | 673 | 377 | 30 | 25 | 75 | 92 | 54 | 20 | |
| 1897 | 659 | 337 | 31 | 19 | 60 | 111 | 82 | 19 | |
| 1898 | 926 | 461 | 77 | 23 | 81 | 148 | 102 | 34 | |
| 1899 | 1,153 | 548 | 47 | 21 | 105 | 173 | 217 | 42 | |

[1] Twelve-month periods beginning April 1, 1878 to 1893; nine-month period beginning April 1, 1894; calendar years, 1895 to 1899.
[2] Includes part Hawaiian.
[3] Japanese not shown separately, 1882-1885; apparently included with "other groups."
[4] Data for 1878-1881 include Tahitians, reported separately in source (1 in 1878, 2 in 1879, 1 in 1880, and none in 1881).
[5] April 1 to December 31.
Source: Hawaii Board of Health, annual reports (see narrative for full citation).

ascertained, the present study is the first full-scale analysis of these data ever attempted.

Although statistics on deaths were first routinely compiled in 1849,[1] separate data by race were not published until 1878. In that year, Captain John H. Brown, agent for the Board of Health, issued a report[2] on deaths occurring in Honolulu, classified by age, sex, nationality, and cause, during the two-year period ended March 31, 1878. The ethnic breakdown was limited to two groups, Hawaiian and non-Hawaiian, and deaths were obviously underreported. Thereafter, however, data were published annually, using a more detailed listing of nationalities.[3] These reports apparently grouped part-Hawaiians with pure Hawaiians, and classified deaths among the Hawaii-born children of foreigners by the nationality of their parents. The source of these data was the burial permits required by law. After a somewhat shaky start, registration of deaths in Honolulu seems to have reached a high percentage of completeness; unlike the reporting of vital events elsewhere in the Kingdom (and births in the city itself), frequently criticized for serious deficiencies, death registration in Honolulu escaped official censure.[4]

Base data necessary for the computation of rates were compiled as part of the censuses of 1878, 1884, 1890 and 1896.[5] Totals were shown for "natives," "half-castes," Hawaii-born children of foreign parentage, and each major foreign group. Beginning in 1890 an effort was made to classify the Island-born non-Hawaiians by national origin. The well-thought-out, practical and meaningful racial classification system developed during this period by Hawaiian census officials and given fullest expression in 1896 unfortunately failed to survive annexation. Many categories were added, dropped, or renamed for the 1900 count (directed from Washington), and a sizable fraction of the part-Hawaiian population was misclassified as Caucasian.[6]

The present analysis required considerable estimation to obtain comparability between the mor-

1. Robert C. Schmitt, "Birth and Death Rates in Hawaii, 1848-1962," *Hawaii Historical Review*, Vol. 1, No. 6, January 1964, pp. 110-124. These data, collected in connection with the census taken in January 1849, referred to the calendar year 1848.
2. *Biennial Report of the Board of Health to the Legislative Assembly of 1878*, pp. 6-8.
3. *Report of the President of the Board of Health* for 1878-1880 (pp. 54 and 56), 1880-1882 (pp. 90 and 92), 1882-1884 (Appendix O, pp. cvii and cx), 1884-1886 (Appendix 1, pp. 7 and 9), 1886-1888 (pp. 65-66), 1888-1890 (tables after p. 68), 1890-1892 (tables after p. 74), 1892-1894 (tables after p. 62), 1894-1895 (tables after p. 14), 1896-1897 (tables after p. 54), and 1898-1899 (pp. 35-38).
4. For comments on the completeness of registration in Honolulu and elsewhere in the Kingdom, see the *Report of the President of the Board of Health* for 1878-1880 (p. 52), 1896-1897 (pp. 55-56), and 1898-1899 (p. 22) and Robert C. Schmitt, *op cit.*, pp. 113-115.
5. *Biennial Report of the President of the Board of Education to the Legislative Assembly of 1880*, table after p. 35; *Census of the Hawaiian Islands Taken December 27th, 1884, Under the Direction of the Board of Education;* Bureau of Public Instruction, *Report of the General Superintendent of the Census, 1890*, tables 1, 4 and 5 and p. 17; Department of Public Instruction, *Report of the General Superintendent of the Census, 1896*, tables III, VI and VII.
6. U. S. Bureau of the Census, *Thirteenth Census of the United States Taken in the Year 1910. Abstract of the Census . . . with Supplement for Hawaii . . .*, table 30, p. 588, and Andrew W. Lind, *Hawaii's People* (Honolulu: University of Hawaii Press, 1955), p. 21. Some of the 1900 ethnic detail for Honolulu was not published until it appeared in connection with the 1910 census reports.

tality and census data. First, allocation of the Hawaii-born population of foreign stock was necessary, chiefly by proration based on the corresponding number of foreign-born females. Second, mid-period estimates for intercensal dates were computed, entirely by linear interpolation. No adjustment of mortality data to a place of residence basis was needed, since both census and death data were on a de facto or place-of-occurrence basis, and in any event nonresident deaths were only a small percentage of the total.

Rates were computed for three periods of approximately equal length: April 1878 to March 1885, April 1885 to March 1893, and April 1893 to December 1899. Such groupings were dictated by small frequencies and erratic annual fluctuations, both in the base populations (impossible to estimate with any accuracy on an annual basis) and the mortality data.

These statistics appear in the accompanying tables. The first reports annual total mortality by ethnic group, from 1878 to 1899. Table 2 presents census data for Honolulu by nationality, 1878 to 1900, with the Hawaii-born children of foreigners reallocated by ethnic group. Mid-period population estimates, average annual mortality, and average annual crude death rates are shown for each of the three periods used in this analysis in Table 3.

Overall mortality was high. For all groups combined, the average annual death rate was 37.8 per 1,000 inhabitants in 1878-1885, 27.0 in 1885-1893, and 26.0 in 1893-1899.

Death rates were particularly high for Hawaiians, Portuguese, and Japanese. Among the Hawaiians and part-Hawaiians, the rate stood initially at 44.3 but fell to 34.7. The Portuguese rate was 37.3 in 1878-1885, but only half as high thereafter. The Japanese, first included in 1886, suffered the heaviest mortality of all major groups, averaging 48.1 deaths annually per 1,000 until 1893, and 36.8 during the remainder of the century.

Lack of adequate census data makes it impossible to compute an accurate death rate for the South Sea Islanders, but available information suggests that this group surpassed all others in loss of life. During the nine-year period ended in March 1888 (when separate data for this group were last published), the South Sea Islanders averaged 13.2 deaths annually. Since their average population for this period was probably not much over 100, their crude death rate must have averaged 130 or so—a rate at least triple the average for all races combined.

Death rates were far lower for the Americans,

TABLE 2.—*Population by nationality, for Honolulu: 1878 to 1900*

| NATIONALITY OR ETHNIC STOCK[1] | DEC. 27, 1878 | DEC. 27, 1884 | DEC. 28, 1890 | SEPT. 27, 1896 | JUNE 1, 1900[2] |
|---|---|---|---|---|---|
| All nationalities | 14,114 | 20,487 | 22,907 | 29,920 | 39,306 |
| Hawaiian ("native") | 9,272 | 9,003 | 8,562 | 7,918 | 8,356 |
| Part Hawaiian ("half-caste") | 1,311 | 1,850 | 2,603 | 3,468 | 3,098 |
| American | 765 | 1,417 | 1,639 | 2,074 | ([3]) |
| British | 636 | 936 | 1,069 | 1,308 | ([3]) |
| Portuguese | 308 | 690 | 2,713 | 3,833 | ([3]) |
| Chinese | 1,395 | 5,433 | 4,913 | 7,693 | 9,061 |
| Japanese | 427 | 54 | 511 | 2,381 | 6,179 |
| South Sea Islanders ("Polynesian") | | 131 | 77 | 63 | ([3]) |
| Other nationalities[4] | | 973 | 820 | 1,182 | ([3]) |

[1] According to terminology used in the 1896 census; terms used in earlier censuses appear in parentheses.
[2] Not adjusted for apparent misclassification of Hawaiians and part Hawaiians; interpolation of 1896 and 1910 census data suggests "true" totals of 7,916 and 4,050, respectively.
[3] Not reported separately. "Caucasians" in 1900 numbered 12,314, including Portuguese and, apparently, some part Hawaiians.
[4] Includes Germans, French and Norwegians, listed separately in census reports before 1900.
Source: Estimated from data in the 1878, 1884, 1890, 1896 and 1900 censuses (see text).

TABLE 3.—*Population, deaths, and death rates, by nationality, for Honolulu: 1878 to 1899*

| SUBJECT[1] | ALL GROUPS | HAWAIIAN[2] | AMERICAN | BRITISH | PORTUGUESE | CHINESE | JAPANESE | OTHER GROUPS[3] |
|---|---|---|---|---|---|---|---|---|
| Mid-Period population: | | | | | | | | |
| 1878-1885 | 17,033 | 10,707 | 1,064 | 773 | 483 | 3,244 | 762 | |
| 1885-1893 | 22,200 | 11,074 | 1,574 | 1,030 | 2,122 | 5,065 | 378 | 957 |
| 1893-1899 | 29,773 | 11,381 | 2,065 | 1,303 | 3,809 | 7,635 | 2,342 | 1,238 |
| Deaths (annual average): | | | | | | | | |
| 1878-1885 | 643.0 | 474.0 | 21.1 | 19.9 | 18.0 | 78.0 | 32.0 | |
| 1885-1893 | 600.5 | 384.2 | 22.1 | 19.0 | 44.0 | 88.6 | 18.2 | 24.2 |
| 1893-1899 | 775.3 | 411.6 | 38.7 | 20.9 | 70.1 | 122.7 | 86.1 | 25.3 |
| Death rate: | | | | | | | | |
| 1878-1885 | 37.8 | 44.3 | 19.8 | 25.7 | 37.3 | 24.0 | 42.0 | |
| 1885-1893 | 27.0 | 34.7 | 14.0 | 18.4 | 20.7 | 17.5 | 48.1 | 25.3 |
| 1893-1899 | 26.0 | 36.2 | 18.7 | 16.0 | 18.4 | 16.1 | 36.8 | 20.4 |

[1] Periods run from April 1, 1878 to March 31, 1885 (7 years), April 1, 1885 to March 31, 1893 (8 years), and April 1, 1893 to December 31, 1899 (6.75 years).
[2] Includes part Hawaiians.
[3] Includes Germans, French, Norwegians, South Sea Islanders, and other nationalities.
Source: Computed from tables 1 and 2.

British, Chinese, and miscellaneous categories. Initially in the 20-26 range, rates for these groups quickly dropped below 20 in most cases, and in one instance (for Americans between 1885 and 1893) fell to 14.0.

These rates seem more meaningful when compared with corresponding data for other areas and periods. In Massachusetts, for example, the crude death rate averaged 19.3 during 1878-1884, 19.6 for 1885-1892, and 18.7 for 1893-1899—far lower than the Honolulu averages for these periods, but almost identical to the corresponding rates for Americans living in Honolulu.[7] For the United States death-registration area in 1900, the rate was 17.0 for whites and 25.0 for nonwhites.[8] By 1964 the United States death rate had fallen to 9.4, and ranged from 5.3 in Hawaii (the lowest State) to 11.5 in Missouri (the highest).[9] Only a few nations exceed 15 today; examples include Burma (21.3 in 1963), Morocco (18.7 in 1962), Guatemala (17.2 in 1963), and Madagascar (15.8 in 1963).[10] The Honolulu rate in 1964 was 5.1, about one-seventh as high as in 1878-1885.[11]

Crude death rates can be very misleading unless standardized for differences in age and sex composition. A predominantly youthful group will often have a rate far lower than a group with many older members, even though the two groups may differ but little in age-specific mortality experience. Inasmuch as the immigrant groups in Hawaii consisted largely of young adults, while the native Hawaiians included a high proportion of older persons, interracial comparisons based on crude rates could well present a distorted picture.

An effort was accordingly made to compute the "expected" number of deaths, based on the assumption that age-specific mortality was identical for all groups. Deaths by age were available for the entire period under study, although these data were unfortunately not cross-tabulated by nationality. Mortality data for three-year periods centering on the 1884 and 1890 censuses were used for this comparison. Age distributions for the Chinese and Portuguese living in Honolulu were published for 1884. It was necessary to assume that the age pattern for each group in Honolulu paralleled the pattern for that group in the Kingdom as a whole in 1890.

The 1883-1886 data revealed wide variations among groups. Based on their age composition, "expected" deaths for the Chinese numbered 461,

TABLE 4.—*Expected and actual deaths, by nationality, for Honolulu: 1883–1886 and 1889–1892*

| NATIONALITY OR ETHNIC STOCK | EXPECTED DEATHS[1] | ACTUAL DEATHS | | |
|---|---|---|---|---|
| | | *Number* | *Annual rate* | *Percent of expected* |
| *April 1883–March 1886* | | | | |
| All groups | 1,774 | 1,774 | 28.9 | 100 |
| Portuguese | 72 | 83 | 40.1 | 115 |
| Chinese | 461 | 303 | 18.6 | 66 |
| All others | 1,241 | 1,388 | 32.2 | 112 |
| *April 1889–March 1892* | | | | |
| All groups | 1,980 | 1,980 | 28.8 | 100 |
| Hawaiian and part Haw'n | 1,016 | 1,267 | 37.8 | 125 |
| American | 157 | 71 | 14.4 | 45 |
| British | 101 | 58 | 18.1 | 57 |
| Portuguese | 239 | 177 | 21.7 | 74 |
| Chinese | 356 | 252 | 17.1 | 71 |
| Japanese | 38 | 81 | 52.8 | 213 |
| Other groups | 73 | 74 | 27.5 | 101 |

[1] Based on age composition of each group and age-specific death rates of all groups combined, as estimated from 1884 and 1890 census data.

Source: Computed from tables 1 and 2 and data in 1884 and 189 censuses (see text).

while actual deaths amounted to only 303, or 66 percent of the "expected" figure. The Portuguese, in contrast, recorded actual mortality 15 percent in excess of their "expected" total. Full information appears in Table 4.

Even greater contrasts were evident for 1889-1892. The best ratios were those computed for the Americans and British, with actual mortality respectively at 45 and 57 percent of the "expected" totals. Ratios were somewhat higher for the Chinese (at 71 percent) and Portuguese (at 74). Above-average ratios were computed for the Hawaiians and part-Hawaiians, whose actual mortality was 25 percent over the "expected" total, and the Japanese, with more than double the "expected" number of deaths. Crude death rates at this time ranged from 14.4 among the Americans to 52.8 for the Japanese.

The effect of nonresident deaths on these comparisons is difficult to assess. John Brown complained in 1884 that "the death-rate of Honolulu . . . is unfair; the number of non-residents dying in Honolulu is increasing continually . . . The Chinese laborers, particularly, find their way to Honolulu when sick, and many die within a few hours after landing."[12] Records on nonresident mortality, first compiled in 1884-1885, revealed an almost steady decline in its importance, from 11 percent of all deaths initially to two percent near the end of the century. Some Honolulu residents, moreover, died away from the city and never appeared in its death records. Lind has ob-

7. U. S. Bureau of the Census, *Historical Statistics of the United States, Colonial Times to 1957* (Washington: Government Printing Office, 1960), Series B-155, p. 30.
8. *Ibid.*, Series B-130 and B-133, p. 27.
9. U. S. Bureau of the Census, *Statistical Abstract of the United States: 1965* (Washington: Government Printing Office, 1965), table 64, p. 57.
10. *Population Index*, Vol. 31, No. 3, July 1965, table 2, pp. 395-397.
11. *Annual Report, Department of Health, State of Hawaii, Statistical Supplement, 1964*, p. 27.
12. *Report of the President of the Board of Health . . . 1884*, p. civ.

served that large numbers of the older immigrants returned to their homelands to die.[13]

It is clear, in any event, that several of these immigrant groups suffered appallingly high death rates, often far in excess of those experienced by the native population. What was the reaction to these differentials?

The plight of the Hawaiians aroused considerable alarm. Missionaries, government officials, medical workers, and visiting writers expressed their concern in a great outpouring of speeches, reports, and articles.[14] Their tone was variously resigned, panicky, analytic, or moralistic.

Mortality rates among non-Hawaiians, in contrast, aroused far less attention. Published comment appears to have been limited, for all practical purposes, to brief papers by Caton and Lyman,[15] some incidental remarks by the Bureau of Immigration,[16] and the occasional observations of government physicians.[17] Histories of specific immigrant groups make little or no mention of health problems. The same lack appears in the general histories of Hawaii.

The Bureau of Immigration seemed to be more interested in the condition of laborers upon their arrival than in their health after becoming Island residents. Illness or death while in transit, and the need for strict quarantine enforcement in Honolulu, particularly concerned the Bureau.[18] Only a few references appear regarding subsequent health matters. One noted: "The impression both of the members of the Board and of Mr. Bingham was that searching enquiry should be instituted, as to whether these South Sea Islanders were actually holding their own, whether they were only swelling the death rate, whether they contributed to the maintenance of the Polynesian race in these Islands . . ."[19] Concerning Japanese plantation workers, the Board noted: "They are not in the aggregate as healthy as other nationalities, a larger percentage being off duty from slight ailments."[20]

Government physicians, reporting in 1892, were somewhat more specific. Dr. Herbert wrote from Wailuku: "With regard to diseases of any special race, I may say the Enteric fever was almost entirely confined to the Japanese . . . The immunity of the Chinese and Portuguese . . . is remarkable . . ."[21] In North Hilo, Dr. Thompson found health good "save the Japanese laborer, who seems to lack sufficient stamina to withstand even the slightest ailment . . ."[22] Dr. Stow in Makawao and Dr. Davison in Lahaina observed considerable beriberi among the Japanese.[23]

Why was so little concern voiced over these high immigrant death rates?

A major reason was the fact that accurate death rates were not even computed until the turn of the century, when mortality levels had subsided to less alarming proportions. Although annual totals were compiled as early as 1878 and crude rates were calculated for Hawaiians in 1884, the lack of good postcensal estimates discouraged comprehensive treatment of interracial differences in death rates for many years.

Lacking such rates, most observers tended to infer mortality trends from changes in population totals. Among Hawaiians, low fertility and a significant (but little recognized) net out-migration exaggerated the appearance of depopulation. Among the foreigners, in contrast, heavy in-migration replaced the population far faster than high death rates and out-migration depleted it, and resulted in rapid population growth.

Even when crude death rates by race became available, their true significance was masked by the age and sex composition of the immigrant groups.

It should also be recognized that some of the highest rates related to relatively small base populations. In 1889-1892, for example, the Japanese death rate was 52.8 but entailed only 27 deaths annually. The Hawaiian rate, in contrast, was only 37.8, but annual mortality averaged 422.

Finally, public concern or its absence probably reflected different attitudes toward various ethnic groups. Immigrants may have been viewed more as economic resources than as suffering individuals.

Whatever the reasons, general awareness of the high 19th century death rates among Hawaii's immigrant peoples seems long overdue. ■

13. Andrew W. Lind, *op. cit.*, p. 101.
14. For example, Rev. Artemas Bishop, "An Inquiry Into the Causes of Decrease in the Population of the Sandwich Islands," *The Hawaiian Spectator*, Vol. 1, No. 1, January 1838, pp. 52-66; Alonzo Chapin, M.D., "Remarks on the Sandwich Islands . . .," *The Hawaiian Spectator*, Vol. 1, No. III, July 1838, pp. 248-267, espec. pp. 262-264; David Malo, "On the Decrease of Population on the Hawaiian Islands," *The Hawaiian Spectator*, Vol. II, No. 2, April 1839, pp. 121-130; Rev. A. O. Forbes, "The Decrease of the Hawaiian People and the Causes Assigned for It," *The Hawaiian Gazette*, January 10, 1883, p. 2; Rev. S. E. Bishop, "Why Are the Hawaiians Dying Out?" (a paper read to the Honolulu Social Science Association in November 1888 and issued as a privately printed pamphlet); *Report of the Commissioner of Labor on Hawaii, 1901* (Washington: Government Printing Office, 1902), p. 12; and W. B. Elkin, "An Inquiry Into the Causes of the Decrease of the Hawaiian People," *The American Journal of Sociology*, Vol. 8, 1902-1903, pp. 398-411. More recent discussions appear in M. A. Taff, Jr., "The Vanishing Race of the Pacific," *Paradise of the Pacific*, Vol. 61, No. 11, November 1949, pp. 20-22; Andrew W. Lind, *op. cit.*, pp. 15-17; and Robert C. Schmitt, *op. cit.*, pp. 111-113.
15. John Dean Caton, "Some Facts Connected With the Vital Statistics of the Hawaiian Islands," pp. 189-195, and Henry M. Lyman, M.D., "Causes of the Low Rate of Mortality Among the Foreign Residents of the Hawaiian Islands," pp. 195-198, in Caton's *Miscellanies* (Boston: Houghton, Osgood and Company, 1880).
16. *Report of the President of the Bureau of Immigration to the Legislative Assembly of 1886*, pp. 108, 115, 150, 161-162, 219-220, 230, 253 and 257-258.
17. Chiefly in the *Biennial Report of the President of the Board of Health . . . 1892*, pp. 32-40 and 63-65.
18. *Op. cit.*, pp. 108, 115, 161-162, 219-220 and 230.
19. *Ibid.*, p. 150.
20. *Ibid.*, p. 253.
21. *Biennial Report of the President of the Board of Health . . . 1892*, p. 33.
22. *Ibid.*, p. 34.
23. *Ibid.*, pp. 36-37.

# Report

# First National Congress on the Socio-Economics of Health Care*

RODNEY T. WEST, M.D., *Honolulu*

I attended the above meeting as a representative of the Hawaii Medical Association. It lasted two full days and was divided into four parts: 1. Orientation and Overview. 2. The Hospital and Its Changing Role in Health Care. (3) Mobilizing Health Manpower. 4. Financing Health Care Services.

The socio-economic climate in which the physician now finds himself has changed markedly during the past several years because of (1) the increasing and somewhat sudden advent of the complexity of medical care; (2) national inflation; (3) the massive intervention of the Federal government into the field of health; (4) the increasing effect and the increasing numbers of medical schools; (5) the great inroads of hospital-oriented outpatient care; and (6) the fact that the whole field of medical care has become more tightly woven into the fabric of our society.

Mr. Theodore D. Woolsey, Deputy Director, National Center for Health Statistics, discussed the use and value of statistics in measuring the state and direction of the nation's health. These statistics are capable of giving quantitative information on (1) the health of the people; (2) their use of health services; (3) resources and facilities that are available; and (4) the environment as it affects health. Collecting reliable health statistics is an expensive process and because of this, there must always be a precise objective before it is worthwhile to establish the mechanisms necessary for data collection. The biggest gap in health statistics in the USA is in mental illness, alcoholism, and drug addiction. The National Center of Health Statistics, however, has as its goal the production of increasingly reliable and more useful health statistics, the presentation of these in a completely impartial fashion, and their timely publication for the use of everyone.

Dr. James L. Dennis, Dean of the University of Oklahoma Medical School, said that the shifting social scene and changing patterns of medical care have become a source of anxiety and despair to many physicians. Much of our energy has been dissipated by vigorous efforts to contain manifestations that actually represent the symptoms of change rather than the primary causative forces. Man's initial response to change is usually one of resistance. Although the threat of Medicare crystallized a smoldering resistance, medicine has accepted other things which have accounted for other radical changes in the practice of medicine in the past 30 years. The burgeoning population is by all odds the most powerful force behind the pressures that have affected and will continue to affect the patterns of medical practice—all else is secondary. It seems prudent to reiterate a truth that appears to have been forgotten by those who would solve the health problems by the legislation of new health programs. Health programs are "people at work," skilled people who must first be produced by education and training. To continue the escalation of new health programs in face of the existing shortage of manpower is unrealistic, if not irresponsible.

Dr. Dwight L. Wilbur of Stanford University, editor of *California Medicine*, discussed the na-

* Held at Chicago, Illinois, January 22-23, 1967.

tion's health manpower. With an increasing demand for health services, it is proper that all segments of society give attention to the changing social philosophy and expectations as to the quantity and quality of medical services, the best organization for the delivery of these services, and the education and efficient utilization of manpower to meet the health needs. At the present, the physician-population ratio in the United States is approximately one per 670. Recent projections indicate that with the number of new medical schools and increases of size of entering classes in existing schools, this ratio will be maintained or perhaps even raised slightly in the years to come. Social demands and scientific advances are forcing the physician more and more into the role of a manager—a role for which he has not been specifically trained and which is new to his tradition. As the managerial function increases, so does the physician's dependence on others. It is, therefore, paramount that each member of his supportive team perform to specifications and that their skills interlock in the right way at the right time. The training of supportive personnel is of more than academic interest to the physician. Their competence has a vital role in his every activity and as medicine continues to advance and demands increase, this dependence can only increase. A committee on health manpower has been organized to work toward finding ways to alleviate the "drastic shortage of health manpower that is confronting the American people," as the problem was described by the AMA's Board of Trustees. This committee is attempting to determine more effective and efficient ways to utilize existing health manpower while seeking ways to develop the necessary additional manpower needed in the medical profession and allied health professions.

In our concern with shortages of personnel, we must not neglect quality of preparation and training in meeting the challenge of numbers. Especially in health care, quantity is no substitute for quality. Too much is at stake. We need not only more health workers, but more importantly, we need good ones. We do need more physicians, and the profession, together with the public, should and will increase its efforts to provide more training opportunities. This can be done, and it is our responsibility to get on with the job now.

Dr. Charles L. Hudson, President of the American Medical Association, discussed medicine's responsibility in the changing scene. He reminded us that 71 out of every 100 people now alive were born after 1921, and these people have been conditioned for the past 30 years to the idea that the government will take care of them. We should continue to show that there is no need for government interference because what is being done is being done so well by private medical enterprise, and therefore there is no need for government. He feels that Medicare is a program that can be lived with at the present time, but he fears that as time goes on, more "needs" will be proposed and the government will render "solutions."

George P. Huber, a Ph.D. in mechanical engineering from the University of Wisconsin, gave the results of an ongoing study directed toward assessing the quality of patient care. The purpose of the study was to learn how to assess the quality of patient care at any general hospital. In this study, they are attempting to develop a formula or mechanism which would aid in decision making and in making managerial evaluations in anything dealing with the quality of patient care in a hospital. The formulas that he used were very complicated and something only an engineer could probably understand, but he seemed to be headed in a direction which apparently is a necessary one in this day of complicated hospital-patient care, and rising costs.

Dwight L. Wilbur spoke again on what he called the "challenge." He said that even though physicians and health personnel are available in plentiful supply, it is necessary to coordinate their skills optimally. He said that there is in a sense, a "brain drain" in our country as far as medical care is concerned. This consists of the progressive diminution in our own practicing physician ranks as members of the profession turn from the primary responsibility of direct patient care to research, teaching, and administrative service. In the past 15 years, the proportion of physicians in full-time private practice has decreased at a rate of almost one per cent annually from almost 75 per cent in 1950 to 62 per cent in 1965. He said that we need more physicians with selective skills and highly specialized knowledge to provide specific types of professional care and the ability to administer to the total needs of the patient. We certainly need more personnel in all health categories. We also need better distribution of physicians and the health service they render.

Thomas C. Points, M.D., of Oklahoma City, Oklahoma, the coordinator of Project Responsibility of the University of Oklahoma Medical Center, spoke about a very interesting plan of action in which they are organizing a prototype pilot project for providing rural medical services, both therapeutic and preventive, by a group of physicians and other medical personnel, with an environment conducive to improvement of distribution and utilization of such manpower and services while retaining high medical standards and economic and educational satisfaction, all on

an ethical and professionally acceptable basis. This is a very interesting set-up in a community where there were no physicians. The community center was paid for by the community itself and it was built with the realization that physical facilities alone will not attract and hold health personnel. This center was built on the idea of a community center, the medical facilities being part of this center. This health center cares for acute emergencies, uncomplicated deliveries, and patients with nonserious illnesses. Patients with more unusual and serious problems are transported to the nearest approved and completely equipped staffed medical hospital center. For the most esoteric problems, helicopter-ambulance service is provided through the University of Oklahoma Medical Center. The center is staffed with permanent physicians who live in and become a part of the community life. These consist of an internist, a pediatrician, and a well-trained general practitioner. They all act as family physicians and their work is supplemented by teaching consultants, who are either part-time voluntcer practicing physicians on the medical center faculty, or full-time professors, or both. In addition to the physicians, the center would be staffed with registered nurses and a public health nurse, a professional social worker, and a registered pharmacist. These physicians charge standard fees according to a schedule acceptable to the Oklahoma State Medical Association. Originally, the professional people are guaranteed a minimal annual income, and if collections do not equal the guaranteed income, the difference is paid to them from trust funds which are to be developed by the medical center. The whole project was an interesting one and seemed to be a very successful one. A similar set-up in a distressed or substandard area of an urban community was discussed by Dr. Mark H. Lepper from the Presbyterian-St. Luke's Hospital complex in Chicago, Illinois. The center is located in the community and is attached to or affiliated with a medical school, teaching hospital, or community hospital and bridges the gap between the first-seeking medical care by the family and the proper immediate solution or referral to more definitive care. These centers are being established in many cities.

Brigadier General Robert A. Patterson, Medical Corps, U.S. Air Force, who is Director of Plans and Hospitalization, Office of thc Surgeon General, discussed manpower requirements and productive measurements. In his project, hc was trying to find a means by which the type and number of personnel could be allocated to any type of medical facility by using the type and quality of the patient load of that facility. He has designated a formula with which he hopes to accomplish this purpose. For instance, he found that the hospital stay for the military is about twice that of dependents, and that staff utilization during the first three to five days of hospitalization was about ten times greater than in later periods of consecutive hospitalization and that one-fourth as many personnel are required to provide an outpatient treatment as are needed to provide care for a patient occupying a bed for one day. With all these data, he is developing productivity measurement techniques so that the average number of required hours for each labor category; that is, physicians, nurses and other officers, airmen, and civilians can be measured against all (labor) manpower input, but also separately for each of the four personnel categories. He feels that establishing this formula and these standards will be a major aid in coping with manpower shortages in the health care field.

Dr. Carl R. Ackerman, Chairman of the Board of Directors of the National Association of Blue Shield Plans, said that the medical profession must do one of two things in the immediate future. It has to demonstrate leadership in the development of programs to finance medical care, or it will have to forfeit the whole thing finally. He said patients want a mechanism by which to budget their medical costs within reason. Sometimes we feel that there is an overemphasis on security at thc expense of responsibility, but he pleaded that wc live with the facts as they are, and the facts are that security has become one of the primary drives of a nation that has, by and large, been able to satisfy its more immediate needs. Furthermore, uninsured medical expense, in the view of much of the population, is one of the most dire threats to that security. He appealed for cooperation and collaboration by all who desire to avoid the snares and pitfalls that have confronted other nations in the financing of health care.

Robert M. Sigmond, Executive Director of the Hospital Planning Association of Allegany County, Pennsylvania, said that in many areas emergency rooms and hospitals have deteriorated into supermarket-type health facilities which finally become too crowded to properly take care of emergencies. Most of the demands on these facilities are from people who do not have what doctors consider emergencies. People just seem to want care at their own convenience and so some hospitals are setting up services for "nonemergencies." If all hospital emergency rooms were adequately staffed for the total public demand, about one-fifth of the physician manpower would be involved. Patients, however, can be educated to the proper function of the emergency room if other facilities

are available. It is too bad that most emergency rooms are at present just advanced dispensaries.

Rita R. Campbell, Ph.D., Archivist and Research Associate in the Hoover Institution at Stanford University, spoke about the economic environment of prepayment insurance and after discussing the various facets of this problem ended by making the following observations: "During the past quarter century a great debate has risen in this country about the welfare state. I submit to you that our private enterprise system has brought this nation to a level of well-being which makes further debate about the welfare state passé, irrespective of what the merits of the debates may once have been." The poor and the unfortunate in our society must be aided, and in accordance with the American tradition, generously so, by both private and public means. But in doing this, there is no need to force the whole population into an ever-expanding web of compulsory governmental welfare programs for everyone. The United States is now at a level of well-being where the individual can lead a much fuller life, both materially and spiritually, than he could a century, or even a quarter of a century, ago. The income of the average person in this country is now high enough so that he can buy his own health insurance policies, his own life insurance policies, his own retirement policies, not to mention his own cultural and recreational activities. This way he can obtain the things he desires and not what some bureaucrat feels is good for him. This is the road to a truly great society, not the path of the ever-proliferating Federal programs which inevitably must interfere with individual liberty and weaken state and local governments and voluntary agencies.

Mr. Martin D. Miller, Vice-President and associate actuary of the Equitable Life Assurance Society of the United States, discussed "patterns for the future." One does not have to be a public opinion analyst or a student of political science to grasp at least the main outlines of what has happened in this country in the area of health care. Adequate health care for all Americans has been moved from the realm of a debatable social issue to a position of public policy. In consequence, private health insurance is now markedly moving away from what has been considered as confirmed opposition to government involvement in health matters and towards a cooperative, participative arrangement whose scope and direction are not yet clearly perceived. We are seeing the evolution of a complex series of interrelationships among the problems of planning and organization of facilities and service, recruitment and training of health manpower, provision of quality care, and cost and financing of such care. Private health insurers are prepared to accept this development with a new awareness of their need to be responsive to their responsibilities. The need for improvement in the quality of care is being given increasing attention by the public, but this quality is primarily the responsibility of the providers themselves. Thus, it is clear that the concern of health insurers in this area must continue to take the form of cooperation with the providers of health care. We insurers stand in a position of trustee for our insured, charged with the responsibility to represent the best interests of consumers of health care.

The health insurance business last year adopted a policy and is developing a program in support of community health planning based on (1) active involvement in community health planning groups through appropriate participation of qualified insurance personnel in state and area-wide groups; (2) financial support of community health planning operations by allocation to appropriate groups funds provided on an industry-wide basis; (3) practical back-up of industry participants in community health planning assignments with background material, information, and counsel. The health insurance business is acutely aware that any goal can be achieved only by close and realistic cooperation among and with the medical and allied professionals and all other providers of health care. They invite us to join them in building the future.

Lawrence A. Hill, Director of Program and Hospital Administration, University of Michigan, said that the financing of health services is no longer a part-time concern for the provider of care. It is a highly complex activity demanding the full-time attention of professionals in that field. The notion that physicians or hospital administrators in a three-day convention can lay down inviolable policies for financing care is no longer tolerable. Professional providers of care must recognize this and delegate such matters to the profession of financing care.

Our private economy has produced the highest standard of living in the world. In general, it has been responsive to demand and perhaps somewhat ahead of demand in some cases. The help sector, however, has lagged behind in some areas. It can no longer do so. The demand is here. The private mechanism for meeting that demand is here, and through that mechanism demand can be met. I am willing to wager that it will be done. ■

888 So. King St.

# Letter To The Editor

## Typhoid Fever

To the Editor:

Since the advent of required immunization to typhoid fever in 1942, Hawaii has had an excellent record with regard to the incidence of typhoid fever. During the past 15 years, up to 1966, there have been 14 cases reported. In eight of these years, no cases were reported. The highest number of cases reported has been three, in 1957 and again in 1961. The cases in the past 15 years have been of two types: sporadic, with no traceable source, and carrier-associated family cases.

In the 15 years prior to required immunization, there were 1,136 cases, an average of 76 cases per year, the range being 56 to 121 cases. With this background, the recent outbreak of seven cases of enteric fever associated with a family party came as quite a surprise.

On July 13, 1966, an organism isolated from a blood culture was sent to the State Health Department for confirmation as S. typhi. The specimen was from a 15-year-old Japanese boy who was hospitalized for a febrile condition. The laboratory made a presumptive identification of the organism as S. typhi and notified the Epidemiology Branch of its findings.

The word "TYPHOID," to an epidemiologist's ear, is like the clang of a firebell to an old fire horse. It may be the signal of an outbreak. There is always the chance that any case may be the entree into a fascinating search. The attending physician was contacted, and with his cooperation the patient was interviewed. It was discovered in this first interview that a friend of the boy, another 15-year-old, was in the same hospital, with symptoms compatible with typhoid fever. In questioning this patient, certain common source situations were discovered and more ill friends began to appear. At one point, it appeared that a school cafeteria association was the answer; but as more evidence accumulated, it became evident that a large family party given to celebrate a high school graduation was the origin of the outbreak.

On June 4, 1966, a family party attended by 109 individuals was held. Seven items of food were on the menu, six of which were prepared by family members and the seventh, Chinese noodles, was procured from a local restaurant.

The plan of investigation was as follows:

1. Collect urine and stool specimens for three successive days from all attendees at the party.
2. Collect urine and stool specimens from all food handlers associated with the preparation of the offending meal for three successive days.

The information derived from this simple procedure is all that is needed to arrive at a simple deductive answer as to the origin of the outbreak. It would appear easy to do. Not so. Difficulty was encountered at several points. Pride is a force more potent than reason. We had great difficulty in getting the names of those attending the party, especially the special guests of the party honoree. It was finally agreed that if the organism was positively confirmed to be typhoid, he would supply us with the names. Fortunately, he kept his promise when we had a positive identification of the organism. Another unfortunate discovery in the progress of the investigation was a persistently positive stool in an asymptomatic grandmother of one of the victims, who lived in a home where one of the dishes was prepared. It looked very much as if she was the cause of it all, but repeated questioning produced continual denial that she had anything to do with the preparation of the meal; however, she did attend the party and ate the meal.

The solution to the puzzle came with the laboratory work on the personnel in the Chinese restaurant: one of the cooks was found to be shedding S. typhi. She had prepared the noodles, picked them out of the large cooking vat with her bare hands, and put them in serving containers. She did not eat the meal involved.

All the five bacteriologically proven cases, and the cook who prepared the noodles, were harboring a similar organism, Salmonella typhi, Vi phage Type A.

This is the first food-borne outbreak of typhoid in Hawaii in 25 years. The last one, in 1942, produced approximately 100 cases and five deaths. At that time, there were no therapeutic agents of value, the herd immunity was low, and deaths occurred. In this recent outbreak, the herd immunity was high: 109 of the 110 interviewed had been immunized at some time against typhoid, 74 of them since 1960. Three of the confirmed and two of the suspect cases had been immunized in 1963, and one confirmed and one suspect case in 1964. Twenty-three people vaccinated in 1965 and 1966 did not become ill. The other case, the grandmother mentioned above, had been vaccinated in 1942. The carrier had been vaccinated in 1953 when she came to this country from Macao.

One of the outstanding features of this outbreak was the mildness of the disease. These people were not very sick and they did not have complications. The disease was so mild that it made diagnosis difficult. Three cases recovered clinically without antibiotics, one was subclinical, and four were treated with antibiotics.

Two of the cases continued to shed bacteria so their physicians were supplied with Ampicillin by the Health Department in sufficient amount to provide 100 mgm/kilo/day for 28 days. The food handler, established as the carrier, was put on this same schedule.

This outbreak demonstrated the fallacy of relying heavily on the Widal reaction in establishing a diagnosis of typhoid. The original case had a 1:80 "O" and a 1:160 "H" titer on July 11, 1966 and one week later the "O" titer had dropped to 1:20 and the "H" titer to 1:80. This is not a rare finding. One must keep in mind that "H" titers of 1:1600 are not unknown as a result of vaccination alone. Though "O" titers are more helpful, the possibility of false positives is always present.

It may be concluded that the only reliable method of diagnosis of enteric fevers in the inoculated subject is the isolation of the causative organism.

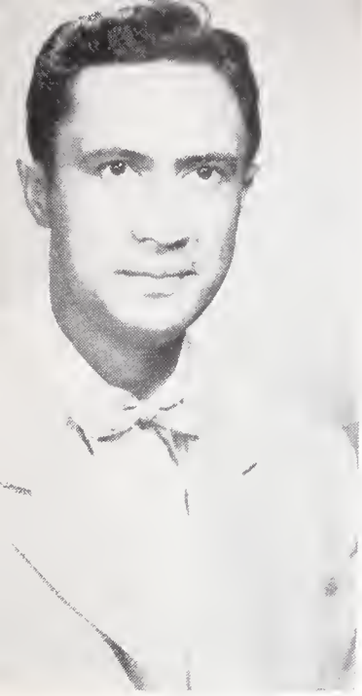
The treatment of typhoid fever has changed since our last outbreak from symptomatic to antibiotic. Various antibiotics are used with varying effectiveness. Chloramphenicol has proved the most effective for treatment of the clinical disease and Ampicillin appears to be the best agent to treat the carrier state. The tetracyclines are usually used when chloramphenicol is not tolerated. After clinical recovery, treatment should be continued for ten days. This will reduce the incidence of relapse and hopefully reduce the shedding time of the patient.

The treatment of chronic carriers appears to be successful with the use of large doses of Ampicillin for long periods. The recommended course is 100 mgm/kilo/day for 28 days. The State Health Department is attempting to eliminate all the known carriers in the State by furnishing the necessary Ampicillin to complete this regimen in each case.

More than half of all typhoid carriers give a negative history of typhoid fever. Both carriers discovered in the State this year had negative histories for the disease. One very important fact to bear in mind regarding carriers of enteric pathogens is that shedding is not a constant phenomenon. This is the reason for requiring three consecutive negative stools before certifying cure in most of the enteric diseases. It is our plan to follow treated carriers for two years.

RALPH B. BERRY, M.D.

*Epidemiologist, Department of Health*





# *The President's Page*

It gives me a great deal of pleasure to be able to reach the membership of the Hawaii Medieal Association through this page. Over the next year there will be many subjeets that could be well diseussed on this page; however, I will try to bring to your attention those subjeets that are most eurrent at the time the article appears. Although we will be discussing many subjeets, you must keep in mind at all times that we are first and foremost physicians whose purpose and objeetive is to alleviate and prevent illness. However, recently medicine has become more and more involved in the socio-eeonomic affairs of the community, state, and nation. During the reeent American Medical Assoeiation meeting in Atlantie City, diseussions in the formal meetings and in the hallways eovered sueh subjects as health eare cost, therapeutie abortion, researeh, medieal manpower, planning and development, disability insurance program, political aetion, generic preseribing, government health programs, etc. As one looks over these subjeets diseussed at the meeting one ean see how involved we have become in many areas. It would be impossible to eover all of these subjects on one page and so I would like to eonfine my discussion to two government health programs.

First—Publie Law 89-239, the Heart Diseasc, Caneer, and Stroke Amendment to the Public Health Act, establishing the Regional Medical Programs, was passed and signed on October 6, 1965. The Division of Regional Medieal Programs is an integral part of the National Institutes of Health.

The purpose of Regional Medieal Programs is to encourage loeal initiative to establish systems for developing regional eooperative arrangements among medical eenters, medical schools, hospitals, other clinieal and researeh institutions, and all public and private health agencies and resources of geographical regions, as defined by the people of those regions themselves.

Grants may be made for planning and feasibility studies, as well as for pilot projeets to demonstrate the value of these arrangements and to provide a base of experience for further development of operational grants.

In developing the Regional Medical Programs, the eooperation of praetieing physieians, medieal eenter officials, hospital administrators, and representatives from appropriate voluntary health agencies is sought. To insure this cooperation, the planning grant application must designate a Regional Advisory Group which is broadly representative of the health resources of the region. Further, the operational grant application must be approved by this group.

The officers from the Hawaii Medical Assoeiation and Honolulu County Medical Soeiety reeently met with representatives from the Division of Regional Mcdieal Programs. To date no grants have been made in Hawaii. To my knowledge one application has been formally submitted, but no action has been taken to date.

The second government health program that I wish to discuss is Publie Law 89-749, the so-ealled Comprehensive Health Planning and Public Health Services Act, which beeame law on July 1, 1966. The objeet of this law is broad enough to eventually eover every health program and aetivity now in existence. A State Health Planning Counеil, on which by law must have at least 51 per cent representation, consumers, will be appointed by Governor Burns to draw up a Comprehensive State Health Plan. The Department of Health has been designated by Governor Burns as the agency to administer the State's Health Planning function.

It behooves all physieians in the State of Hawaii to be kept informed on these mentioned two laws, whieh will play a more and more important part in the practice of medieine in the future.

B. Allen Richardson M.D.

HAWAII MEDICAL JOURNAL

# Editorials

## Generic Equivalence

The patent is an interesting social device, and was a valuable one in the pharmaceutical field during the years when it enjoyed official governmental approval and protection. It worked like this: in exchange for being informed of the details of a manufacturing process, the government would guarantee the man or firm who disclosed it (made it "patent," as the law read) a monopoly of it for a stipulated period of years. Thus he could make a profit, in the traditional "American Way."

The manufacture of drugs in the United States has thrived mightily under this protective legal device; a comparison of the 1946 and 1967 editions of the *Physicians' Desk Reference* would astonish you, and the overwhelming majority of the new drugs there were developed in the United States—for profit.

It has been suggested—nay, proclaimed—that the profit has been excessive, unreasonable, and exorbitant. If so, it seems curious that the drug companies' record of earnings vs. expenses doesn't show it. The indications are that between research costs, quality control costs, other FDA requirements, and reserves against the hazard of lawsuits for drug reactions, the profits are not out of line.

Drug firms which don't distribute their products by brand name, but as unbranded or "generic" drugs, are not saddled with research or drug development costs and are not necessarily unduly troubled about quality control. A. U. S. Navy review of 18 drug manufacturers offering a "generic" drug—all of them approved by the FDA—found only four satisfactory!

The fact is that "generic equivalence" means no more than the particular set of standards you require a generic drug to meet, and the FDA's minimum standards are not as high as those of Bethesda Naval Hospital. Did you ever drink home brew? It's the exact generic equivalent of San Miguel, Kirin, or Budweiser—but few regret its passing! Magnesium hydroxide slurry, at $15 a ton, is the exact generic equivalent of Milk of Magnesia at about $600 a ton—but the crystalline fineness and smoothness of the emulsion, and speed of reaction with hydrochloric acid, might leave something to be desired!

So if a firm's research and development costs consist entirely of sending someone to a library to read about how to manufacture a drug, it follows that they can make it more cheaply and sell it for less. Such a firm can stay in business, but it won't make any contribution to the field of new drug development. The Italian firm that the U. S. bought all the generic tetracycline from a few years back isn't interested in doing research to produce new antibiotics. And anyone who thinks the American firms producing it under their own brand names ought to meet the Italians' competitive price, and give away their costly research for free, is either stupid or insincere.

The cost of drugs has risen far less than that of most products in the past decade or two; many of the most expensive ones have become a lot less costly, in fact. Notable among these are the steroids and the antibiotics.

And what these drugs can do for sick persons has increased fantastically, as we all know. The mere fact that a substantial part of their cost has to cover items like research, and quality control, and advertising to meet competition, does not mean they aren't worth what they cost; they most assuredly are. Think what it cost a man 30 years ago to have pneumonia, or a carbuncle—very little for his medicine, such as it was, but in terms of time off work, hospitalization, and surgery, it was five or ten times more costly than it would be today.

The fact is that there's nothing intrinsically wicked about charging enough for a good product to pay the cost of keeping it good and guaranteeing it so, plus a profit; there's stiff enough competition in the pharmaceutical trade to protect the public against gouging. Quality control is assured by brand name as no amount of legal requirements can assure it. Prescribe by brand name—and be sure!

# Medic Alert Saves Lives

Ten years ago, a California physician whose daughter almost died as a result of a reaction to a skin test with tetanus antitoxin, founded the Medic Alert Foundation International. Today more than 160,000 people wear the nonprofit Foundation's increasingly familiar stainless steel emblems on the wrist or around the neck, each calling immediate attention to one or more of 200 hidden medical problems. When necessary, by a collect telephone call to the Foundation's Turlock, California, headquarters, physicians and other authorized personnel may obtain additional medical information that may save the life of a conscious or unconscious person wearing a Medic Alert emblem. The telephone number, 209-634-4917, appears on all emblems.

Each emblem carries the words "Medic Alert" and the staff of Aesculapius emblazoned in red enamel. The reverse side of the emblem contains one or more key words, the Foundation's telephone number, and the wearer's identifying number, corresponding to an information card in the Medic Alert files. Thus in an emergency, physicians or others, at any hour of the day or night, can call the Foundation's Central Answering File and obtain further medical facts plus the wearer's name and address, his next of kin and the name of his family or personal physician.

The American Medical Association estimates that 40 million Americans—one in five—should be wearing a medical signaling device.

The one-time cost of a Medic Alert emblem and round-the-clock information service is $5.00 (sterling silver emblems are $7.50). However, the Foundation provides memberships without cost for persons whose physicians state they are unable to pay.

The Foundation has a dual purpose: (1) to persuade people who need to obtain and *wear* an emblem to do so, and (2) to teach physicians and qualified first aid personnel to *look* for the emblem. At present 30 national and overseas airlines instruct their hostesses to look for Medic Alert emblems, and many industries provide information about Medic Alert in their industrial health programs.

A few of the key words or phrases often used are:

ALLERGIC TO PENICILLIN
TAKING ANTICOAGULANTS
WEARING CONTACT LENSES
HEMOPHILIAC
TAKING DIGITALIS
EPILEPSY
DIABETES
GLAUCOMA
ALLERGIC TO CODEINE

Don't you know patients who should wear such an emblem? Tell them about it! Mail orders should be sent direct to Medic Alert, Turlock, Calif.

# The *Real* St. Francis Hospital

*with apologies to an inadvertently maligned institution.*



HAWAII MEDICAL JOURNAL

# This Is What's New!

• In approximately 1500 consecutive neeropsies earried out in Baltimore in patients over ten years of age, adrenal eortieal adenomas were found in slightly over 1 per eent, adrenal hyperplasia in slightly over 7 per cent, and the **prevalence of hypertension was identical in adrenal adenoma, adrenal hyperplasia** and **control groups.** The results do not support the view expressed over the last few years that 15 to 25 per eent of hypertensives have an underlying adrenal adenoma with aldosteronism as the cause of their hypertension. (*Lancet* [Mar. 4] 1967.)

• The **hypotonia** related to the decreased blood serotonin in infants with **Down's syndrome** is reversed by administration of 5-hydroxytryptophane (5-HTP). Fourteen infants with trisomy-21 Down's syndrome had their hypotonia **improved after ingestion of 5-HTP.** No improvement of intelligence was recorded. (*Lancet* [May 27] 1967.)

• **Smokers** at Harvard and Radcliffe **use the university infirmary** much more frequently than nonsmokers. More offiee ealls were necessitated for **respiratory infections** among the smokers. There is no difference for gastrointestinal disorders between the nonsmokers and smokers. However, the male smokers had higher visits necessitated by **trauma** than the nonsmokers and the female smokers had more **genitourinary problems** than the nonsmokers. (*Amer. Rev. Respiratory Dis.* [May] 1967.)

• Of almost 1,000 patients with **infectious mononucleosis** studied in Norway, the **age distribution** was almost precisely the same as for **gonorrhea,** the mean age in women being 17 years and in men 19.5 years. The investigator believes this pattern supports the previous impression that infectious mononueleosis is **transmitted by kissing.** (*Lancet* [May 13] 1967.)

• The **multitest laboratory,** with patients undergoing blood and urine examinations ineluding extensive blood chemistries, eleetroeardiogram, ehest x-ray, mammography, and simplified psyehological tests, is most useful for **outpatient screening,** although it can be used for hospital inpatients. After scanning the results of the first test the computer reeommends further tests with more detailed examination on an individual basis. (*Hospitals* [May] 1967.)

• The hope that the **thiazide diuretics** might be a good provoeative test for the diagnosis of **primary aldosteronism** appears to be fading. Of 75 hypertensive patients with **low serum potassiums** after thiazide therapy, **none** turned out to have hyperaldosteronism. (*Ann. Int. Med.* [June] 1967.)

• The most common hemorrhagic disorder, **Minot–Von Willebrand syndrome,** has a hereditary pattern with normal clotting and prothrombin times and normal prothrombin consumption times with good clot retraetion. The **ingestion of two aspirin tablets** is a most dependable test for confirming the diagnosis. After the ingestion of 0.65 grams of aspirin the **bleeding time** beeomes significantly **prolonged.** (*Amer. J. Med. Sci.* [May] 1967.)

• **Betamethasone** appears in a double blind study to be a **better topical** corticosteroid than **fluocinolone acetonide.** The author feels that betamethasone more nearly approaehes his eriteria for an ideal topical corticosteroid. (*Arch. Derm.* [May] 1967.)

• A physieian at Guy's Hospital in London, studying the blood glucose levels at the time of glueose toleranee testing, eoneluded that eapillary **blood taken from a warm ear lobe** gives an aeeurate refleetion of the arterial blood glueose and is **superior to the venous blood glucose** in diagnosing diabetes mellitus. He reeommends that capillary blood be subjeeted to the ferricyanide-redueing miero method on the autoanalyzer. (*Diabetes* [Apr.] 1967.)

• One hundred military men who survived a **myocardial infarction** at the age of 40 or less were compared with military controls matched for age. **Striking correlation** was found in the infaret group with **elevated serum cholesterol,** total **sernm lipids, obesity,** and a **family history** of eoronary artery disease. Also noted to a less signifieant degree in the myoeardial infaret group were hypertension, short stature, eigarette smoking, consumption of saturated fats, low intake of unsaturated fats, emotional tension, white race, and family history of hypertension. There was **no association** with consumption of **coffee, alcohol,** degree of **physical activity,** or family history of **diabetes mellitus** or **gont.** (*Amer. J. Cardiol.* [March] 1967.) ■

FRED I. GILBERT, JR., M.D.

HAWAII MEDICAL JOURNAL

# In Memoriam - Doctors of Hawaii

This is the sixty-seventh installment of In Memoriam—Doctors of Hawaii.

## Augustin Averill Crane

Augustin Averill Crane was born in Waterbury, Connecticut, January 9, 1864, the son of Dr. and Mrs. Robert Crane. His father was a physician who came to Waterbury in 1853.

The family moved to New Haven, Connecticut, when Dr. Crane was three, and he attended the public schools there. He received his B.A. from Yale University in 1885 and his M.D. in 1887. For the next year and a half Dr. Crane served as house surgeon at the New Haven Hospital.

In September, 1888, the doctor, accompanied by his wife, arrived in Honolulu aboard the S.S. "Australia" to accept a position as government physician at Makawao, Maui. For over two years the doctor practiced on Maui, covering his district mostly on horseback. He was active in community affairs and served as Secretary of the Maui Rifle Association. On the occasion of King Kalakaua's death in January, 1891, the doctor helped draw up a resolution expressing the sorrow of the people of Makawao.

On March 10, 1891, Dr. Crane and his family returned to San Francisco and from there to New York City where he spent a year in schools and hospitals doing postgraduate work in surgery. For five months Dr. Crane was first house surgeon at German Hospital. While engaged in surgery, he developed blood poisoning and became very seriously ill. Upon his recovery in 1892, he located in Waterbury.

Dr. Crane married Miss Cordelia I. Corbett of New Haven in 1888. The doctor and his wife had two sons and a daughter: Eunice Leola (Mrs. Albert B. Root); Robert, who died at the age of 11; and George Averill. Mrs. Crane died in 1902. In 1904 Dr. Crane married Miss Bessie L. Barlow of Waterbury.

Dr. Crane was visiting surgeon at the Waterbury Hospital and consulting surgeon at St. Mary's Hospital. In addition to his surgical practice he was medical examiner for the city coroner and medical examiner for six life insurance companies. He served for three years as a Captain in the Medical Corps of the State Militia and held the rank of Captain in the U.S. Medical Reserve Corps. During the summer of 1916 he spent three months in various hospitals in France caring for the sick and wounded. For four years the doctor served on the Waterbury Board of Education, the last two years of which he was chairman of the group.

Dr. Crane died on July 6, 1930, at his summer home in Woodbury, Connecticut, at the age of 66.

He was a member of the American Medical Association, the Connecticut Medical Society, and a member of the American College of Surgeons. He was also a Mason and an Odd Fellow, and belonged to the Sons of the American Revolution, the Appalachian Mountain Club, and the Waterbury Country Club. His chief recreation came from traveling. He frequently visited Europe and also traveled extensively in the United States. He spoke German and French fluently and was a well-known Alpine climber.

## Rolando Kuehn

Rolando Kuehn, born in 1860, received his medical training from Jefferson Medical College in Philadelphia, from which he graduated in 1883.

The following year he was ship's surgeon aboard the S.S. "Mariposa." Like many another, he felt the lure of the Islands, and in August, 1884, he left the "Mariposa" to become government physician at Lahaina, Maui. While on Maui, he became a friend of that controversial political figure, Walter S. Gibson, who played such a major role in Hawaiian politics.

During a session of the Legislature in 1886 when the salaries of government physicians were under discussion, Dr. Kuehn was characterized as "always prescribing Epsom Salts" and as being "famous for gossiping" but was stoutly defended by Mr. Gibson. That the real irritant was the doctor's politics rather than his medical ability became apparent in the subsequent remark of one of the legislators that "there is one thing that the doctor knows and that is how to work an election." This referred to the fact that Dr. Kuehn was an election inspector, and in the December, 1886, election at Lahaina he had a high board fence built around the polls which kept anyone from interfering with the voters as they cast their ballots. This was not popular with everyone but did result

*continued page 616*

PROFESSIONALISM

The elderly patient was in hospital because of excessive weakness. The initial CBC revealed a 70 per cent drop in hemoglobin, and this was the subject of comment by the floor nurses. The attending, in searching for a possible cause, ordered a gamut of x-ray and laboratory studies and included, as he should have, stools for occult blood times three.

Physicians well know what this usually means —times three may take a week, what with the nurse forgetting to tell the patient, the patient forgetting the instructions, the facilities not being conveniently available at the propitious moment, etc.

Anyway, lo and behold! this particular study took only three days. But what happened? The laboratory reports, neatly stuck to the proper page on the hospital chart, said tersely: "None," times three. The attending took a second look. The reports obviously referred to "O & P," and no request for a determination of occult blood appeared on the combination requisition–report.

A bit upset at his own foibles, perhaps, the attending flipped the pages back to the order sheet, and amazed himself in that he really had written, and legibly for once: "Stools for O & P and occult blood x 3"! So naturally, he blasted the floor nurse, who naturally (it is always thus) denied it had happened on her shift. Anyway, on some shift or other, somebody, probably the ward clerk, inadvertently omitted the request for a report on occult blood.

So, what's new, Bud? Are you going to editorialize against the inevitable—the human error factor? This can happen to the best people and in the best places, Bud!

No, the point of this story concerns professionalism: Responsible thinking by professional people; in this case, paramedical professionals.

The errors resulting from "nonthink" are expensive. All fields of human endeavor are affected, of course, but it is a particularly serious matter when it occurs in the medical field. A professional is supposed to "think;" a worker is one who just "does." How often do we hear the excuse, the first words of a defensive attitude from one who has committed an error: "Well, I thought . . .", when the error was actually the result of "nonthought!"

NONTHINK I

In our example above, the "nonthink" was initiated by the paramedical person who transcribed the order onto the requisition, failing perhaps to interest herself in the case, before she sent it on down to the laboratory. She just did it; she failed to reason why.

NONTHINK II

There was a complete "nonthink" in the laboratory too, where it was presumably known that this particular patient was severely and unexplainably anemic. However, one must grant the possibility that it is the nature of our system, particularly in a large facility, that one technician does not know what the other has done. Probably, each inpatient's complete laboratory profile is not posted on the wall.

NONTHINK III

Thirdly, and most devastatingly, there was a "nonthink" when the R.N. on the floor read the first of these three reports and posted it, but failed to use her professional mind in the way it was trained to be used—as the doctor's closest assistant. She was the one who had had first and most intimate access to the patient's complete picture by way of the hospital chart.

The attending is not himself blameless either. Perhaps it was his fault for confusing the issue. He really wanted to know about occult gastrointestinal bleeding, so why did he throw in a request for ova and parasite search when he knew all along that that this particular gentlewoman could not have been exposed to any such infestation? He should have THOUGHT before he wrote!

It took another five days to get the next three stool specimens. ■

J. I. FREDERICK REPPUN, M.D.

HAWAII MEDICAL JOURNAL

# Book Reviews

## ★Arthritis and Allied Conditions: A Textbook of Rheumatology, 7th Ed.

*Edited by Joseph Lee Hollander, M.D., 1,355 pp., $32.50, Lea & Febiger, 1966.*

FIVE YEARS have elapsed since the sixth edition of this volume was published and in that time intensive research has produced a massive amount of new material and information. The bibliography is immense and includes information from all sources of rheumatology literature. This volume easily qualifies as a source of information for the everyday clinician or research worker. It is the "Bible" in the field of rheumatology.

ARTHUR K. WONG, M.D.

## Surgery of the Ambulatory Patient, 4th Ed.

*By L. Kraeer Ferguson, M.D., F.A.C.S., with a section on fractures by Louis Kaplan, M.D., F.A.C.S., 807 pp., $17.00, J. B. Lippincott, 1966.*

THIS BOOK, intended to serve as a guide to the practice of surgery on ambulatory patients, covers the whole range of surgical problems, including many that would be treated in the hospital. The author has added a new material on postoperative care of patients with ileostomies and colostomies and wound complications, and a chapter on cardiac resuscitation. This material is a welcome addition to any surgical textbook.

The book is well written and concisely presents the management of surgical problems. My only reservation to its wholehearted recommendation is that, as a guide to various practitioners, including medical students, it may not be specific enough in describing surgical technique and postoperative care. I was not aware that horsehair is still available and used as suture material. For physicians who are familiar with surgical principles, this text would be a welcome addition to their library.

RAYMOND H. FUJIKAMI, M.D.

## Labor: Clinical Evaluation and Management

*By Emanuel A. Friedman, M.D., Med. Sc.D., 397 pp., $13.50, Appleton-Century-Crofts. 1967.*

A BIOSTATISTICIAN'S JOY, this book may not find such favor with the jaded clinician accustomed to the rule of thumb or sweat-of-his-brow method of deduction. The first five chapters seem conventional enough as they give a look at previous investigations of labor and the development of the book's basic hypothesis. But with Chapter 6, the reader is plunged into a maze of means, modes, medians, standard deviations, and percentages, beginning with the Gompertz growth curve ($y=ab^{c^x}$).

The trail leads through all aspects of labor, normal and otherwise, touched by as many variables as can affect labor, and ranging from maternal stature to effects of medications. The first stage of labor is divided into four phases by a most unique approach of plotting cervical dilatation (the ordinate) against time (the abscissa). Thus obtained are the latent phase, the acceleration phase, the phase of maximum slope, and the deceleration phase. By statistical analysis of the labors of 500 nulliparas and 500 multiparas, limits were established for each phase. The result is the famed sigmoid or S-shaped curve of normal labor.

As the bewildered reader, if he is so affected, wends his way through the hundreds of figures with which the book is liberally endowed, he will find that most of the conclusions drawn by Dr. Friedman bear out accepted clinical impressions. However, the reader may take issue with the author's conclusion that amniotomy, in general, is not effective in shortening the first stage of labor; perhaps, in fact, the acceleration of labor may actually be due to a coincidental progression in the active phase of the sigmoid curve. No comparision could be made between willful amniotomy and spontaneous amniotomy. Another observation which may provoke discussion is the conclusion that polyhydramnios is not a primary cause of prolonged labor. Though deliberate in his statements, the author does allow that additional work must be done to further substantiate these conclusions.

The cream for most of us clinicians comes in the book's last 23 pages (of 390) which deal with detection, diagnosis, prognosis, and management of labor. Characterized by a paucity of numbers, this section is instructive to say the least. It fairly bursts with pearls, gems, and other precious forms of advice. The tables and other schematic forms of summary are classic, and without exception all should find this portion of the book of value.

In summation, Dr. Friedman's book for the practicing clinician without statistical background may not find its way into his library. The reams of figures on percentages and like statistical factors tend to overshadow its practical value, which blossoms in its last 23 pages. For those mathematically inclined, the book is a goldmine. Despite the minus effect of its preponderance of numbers, one must not lose sight of the tremendous value of such work as this for cold objectivity as manifested by statistical analysis is very necessary to refute or substantiate clinical impressions often tempered by personal biases.

MILLARD S. L. SETO, M.D.

## Psychotherapy: Myth and Method An Integrative Approach

*By Jan Ehrenwald, M.D., 212 pp., $7.75, Grune & Stratton, 1966.*

DR. EHRENWALD, a knowledgeable practicing psychiatrist, presents in his book the provocative concept that from primitive medicine men, faith healers, operant conditioners, existentialists, and drug therapists (including LSD) to Freudian psychoanalysts (the author considers this to be the most scientific, anti-myth, comprehensive and sophisticated approach to psychotherapy), there are myths involved in all their approaches to the "curing" of the emotional ailments of man. However, rather than stopping there as others have done and "throw the baby out with the bathwater," Dr. Ehrenwald thinks that because man needs his myths (the patients, as well as the therapists who employ them, whether or not they are aware of it) it is not only wise but necessary to incorporate these myths scientifically into the "scientific" approach to psychotherapy.

It is an excellent book which should be read by all physicians. Psychiatrists will find it an extremely interesting and thought-provoking one. Yet it is written in such a clear, concise, and readable manner that a nonpsychiatrist-physician will find it most valuable in furthering his understanding of what a psychiatrist does

*continued page 621*

# University of Hawaii

**Richard K. Blaisdell,** Chairman of the Department of Medicine, has returned from mainland meetings in the field of medical education as follows: 5-10 March, Psychiatry and Undergraduate Medical Education Conference, Atlanta, (he also toured the fabulous USPHS Audiovisual Facility while in Atlanta); 7 April, Medical Records Research, Permanente Medical Group, Oakland; 9-12 April, Preparation for Medical Education Workshop, University of Chicago; 12-24 April, Conference on the Teaching of Cardiology, Atlanta (loves that town!); 25-28 April, Visiting Professor of Medicine, Rutgers Medical School; 29 April-3 May, Amer. Assoc. Professors of Medicine, Amer. Fed. Clin. Research, Amer. Soc. Clinical Investigation, Assoc. Amer. Physicians, all in Atlantic City. In his spare time, Dick has established a hematology research laboratory and is readying a clinical lab for medical student teaching, both at St. Francis Hospital. In collaboration with the Department of Microbiology's Chairman, **Al Benedict,** and **E. Gold,** Dr. Blaisdell has initiated an American Cancer Society grant on fowl paraproteinemia (which sounds like a chicken thing to do). The Department of Medicine eagerly awaits its second faculty member, Professor **Charles A. Nugent,** M.D., endocrinologist, due here from the University of Utah in June. Charles speaks fluent Japanese (to a haole ear) and is a reasonably good scuba diver when he takes enough weights off. Also recently appointed is **Ann M. Budy,** Ph.D., Associate Professor, radiobiologist and an expert on bone metabolism. Dr. Budy is due here in August to be at St. Francis.

Now Hear This: The Division of Speech Pathology and Audiology has appointed **Michael Z. May,** M.S. Ohio, Ph.D. Stanford, as Assistant Professor. Dr. May is an expert on childhood aphasia (how to get 'em to *stop* talking is another problem). The Division has recently been host to the following noted professors of speech pathology: Wm. H. Perkins, Ph.D., U.S.C.; Ernest Henrickson, Ph.D., Univ. of Minn.; M. D. Steer, Ph.D., Purdue. **Thelma Trombly,** Ph.D., Assoc. Prof. from the University of Missouri is currently visiting professor of speech pathology. The Hawaii State Vocational Rehabilitation Plan has three subcommittee members from U.H., Prof. **Merle Ansberry,** on Professional Associations; Dr. **E. Gene Ritter,** on Workshops and Facilities; and Dr. **Glenn Pang-Ching,** on the Blind and Deaf.

**Richard K. C. Lee,** Dean of the School of Public Health, recently returned from Fiji, American and Western Samoa, has announced the appointment of **John M. Hayakawa,** Asst. Professor, and Dr. **E. Ross Jenney,** visiting professor of Public Health. Dr. **Robert E. Mytinger** recently attended an Institute on Comprehensive Health Planning, in San Francisco and Dr. **Robert J. Wolff** visited Noumea, Caledonia in May to participate in a South Pacific Commission Seminar on Mental Health. May 10-12 at the Ala Moana Conference Center, a conference on Legal Tools for Effective Health Administration sponsored jointly by U. H. School of Public Health, Univ. Calif. Schools of Public Health, Berkeley and Los Angeles, American and Hawaiian Public Health Assns. and Hawaii State Health Dept., discussed legal problems related to health.

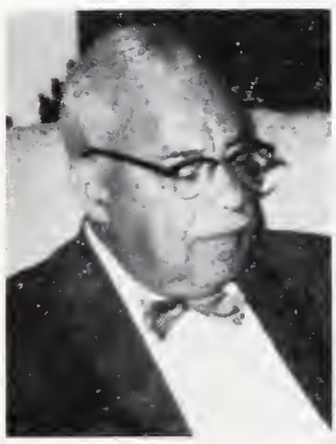
The Department of Pathology is established at Leahi Hospital with a very active program of research—in addition to preparing for medical students. Three members of the Department attended the annual meeting of the Federation of American Societies for Experimental Biology in Chicago recently. Dr. **Ed Nishimura** chaired a session on enzymes and presented a paper, "Variations in pH optima of catalases in response to systemic injury," and Drs. **Y. Hokama** and **H. D. Croxatto** presented "Common immunological antigenic determinants in C-reactive protein and human catalases." Grants have recently been received from the American Cancer Society, from the Ladies Auxiliary of the Veterans of Foreign Wars (cancer research), and the National Institutes of Health "Catalase isozymes in normal and neoplastic tissues," 3 years' support, first year $61,076. **Linda Chun,** a high school scholarship awardee of the Hawaii Heart Association, will be working in the Department of Pathology for 10 weeks this summer.

*News Briefs from the Ivory Tower* might be an appropriate way to title this page, the use of which the University considers to be an honor and a privilege. Our newly formed College of Health Sciences and Social Welfare has recently designated a standing *Committee on Postgraduate Education and Professional Relations,* whose members represent the several schools (Medicine, Nursing, Public Health, Social Welfare) and Hawaii's health community. Each month, the members of this committee and chairmen of departments and divisions, some of whom are remote from the campus, contribute news items thought to be of general interest. Specifically, faculty appointments, honors, travel, papers presented at national meetings, new courses and programs, and building and renovation projects are covered. This page will carry specific examples of what members of the College faculty are actually doing. What will not be attempted here is broad coverage of such general topics as curriculum, research objectives, or service-connected responsibilities. In the future, we hope to keep the reader informed in these broader areas by special articles written by knowledgeable faculty members for publication in other sections of the JOURNAL. ■

ROBERT W. NOYES, M.D.
*Associate Dean for Professional Affairs*

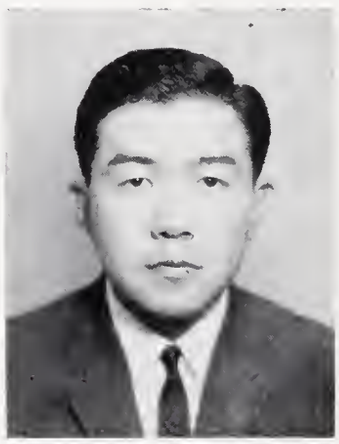
HAWAII MEDICAL JOURNAL

# New Members



**Albert Chandler Johnston, Jr., M.D.**

G. N. Wilcox Memorial Hospital
Lihue, Kauai 96766
RADIOLOGY
Rush Medical College—1929
Internship—Maine General Hospital —1929-1930
Residency—Harvard Medical School Peter Bent Bingham Hospital, Boston—1937-1938



**Donald K. Maruyama, M.D.**

1010 South King Street, Suite 703
Honolulu, Hawaii 96814
ORTHOPEDICS
Northwestern University—1957
Internship—The Queen's Hospital—1957-1958
Residency—Hines V.A. Hospital—1962-1964
Chicago Shriners Hospital—1964-1965
Hines V.A. Hospital—1965-1966



**Alan Pavel, M.D.**

888 South King Street
Honolulu, Hawaii 96813
ORTHOPEDICS
University of Chicago School of Medicine—1958
Internship—New York Hospital—1958-1959
Residency—New York Hospital—1961-1963
Hospital Special Surgery—N.Y.—1963-1966
Memorial Hospital—1965
Bronx V.A. Hospital—1963



**Gayne Chun, M.D.**

1507 South King Street, Suite 303
Honolulu, Hawaii 96813
OTOLARYNGOLOGY
University of Maryland—1958
Internship—The Queen's Hospital—1958-1959
Residency—The Queen's Hospital—1962-1963
Strong Memorial Hospital—1963-1966

# County Society Reports

## Hawaii

Seventeen members were present at the April 20 meeting. Dr. Best announced that the date of the Oral Cancer Detection Clinic would be June 6, and that the Diabetes Detection Survey would be held on May 12. Dr. Miyamoto advised that the HMA would propose a $30 increase in state dues. It was voted to endorse the increase in dues. Rather than a Society donation, it was voted that donations for the new Boy Scout camp be made on an individual basis. The members were asked to complete the DSS claim forms and bill according to the individual fee. It was decided to ask Dr. Schnack to postpone his mental health workshop. The meeting ended with a talk by Col. Wm. Burkhalter on "Common Pitfalls in the Management of Trauma to the Limbs of Children."

* * *

At the May 25 meeting it was voted to address a letter to Dr. Raymond Eklund thanking him for his long and able support of the Society. The President reviewed a list of HMA committees which need members from this county. A letter from HFPC seeking funds was filed. Drs. Okumoto, Wipperman, and Miyamoto reported on the HMA's House of Delegates meeting. The meeting

*continued page 616*

HAWAII MEDICAL JOURNAL

# Notes and News

## Professional Moves

We have noticed an unusual paucity of news relating to professional moves and alliances in the past few months. Otolaryngologist **Gayne Chun** bravely announced his solo opening at 1507 S. King. We do, however, expect a deluge of announcements after July when the new crop of physicians starts into practice. We envied veteran Kamuela physician **R. T. Eklund's** decision to leave for Las Vegas after 30 years in the islands. He has accepted an eight-hours-a-day, five-days-a-week position as an emergency room physician at Southern Nevada Memorial Hospital. We thrilled to this concept of a 40-hour week for physicians.

## Elected, Appointed, and Honored

It seems that our honorable Governor Jack Burns has a never ending task of filling vacancies on various boards and commissions. Anti-war protagonist, **Willis Butler,** whose term on the Board of Medical Examiners expired in December last year, was considered to have embarrassed the Governor by participating in a protest demonstration at the East-West Center when LBJ was here. Willis and **Allen Richardson** were replaced by **Shig Horio** and **Mor McCarthy. Louis Rockett** and **Theodore Oto** were also appointed to the Board of Medical Examiners. **Roy Kaye** and **Marion Hanlon** were appointed to the Commission on Children and Youth. We also learned that neurosurgeon **Maurice Silver** is the new part-time medical adviser for the Workmen's Compensation Division of the State Department of Labor and Industrial Relations. Perhaps we can now expect a fair shake with our workman's comp fees, we hope.

We congratulate the following: **Robert Miyamoto** of Hilo for his selection as President-elect of the HMA; **Billie Strother** for her election as Maui County Medical Society President; **Frances Nakamura** and **Raymond Wong** for their election as Fellows in the American Academy of Pediatrics.

We learned that **George Henry** was elected President of the Hawaii Thoracic Society while **Carl Mason** was elected Vice President and **William Myers** Secretary-Treasurer. A rather exclusive group has reared its head in this heterogeneous community of ours. The Hawaii State Society of Colonial Wars named **Clagett Beck,** Chancellor and **Alexander Haff,** Surgeon. The membership is open in general to descendants of persons who served with military forces or as public officials during the period between the founding of Jamestown in 1607 and the Battle of Lexington in 1775. **John Milnor** was elected Treasurer of the Hawaii Association to Help Retarded Children and **Mike Okihiro** is the new head of the advisory board of the Hawaii Chapter, National Multiple Sclerosis Society. The new Chapter will get together for mutual study of ways victims of multiple sclerosis can help themselves. **George Mills** is a new board member of Goodwill Industries for the Handicapped, and **Paul Caldwell** and **James Mitchell** are directors of the Big Island Chapter of the Hawaii Heart Association.

## HMA Convention

The 111th Annual Meeting held at the Princess Kaiulani between May 17 and May 20 was the most successfully attended in recent years. We hesitate to comment on whether this can be attributed to the panel of excellent speakers, the sexy topics, the conviction of members, the excellence of the President, or the mere discontinuance of registration fees, though we would tend to weigh the last rather heavily.

We arrived timorously on time for the 7:15 A.M. opening remarks which started promptly at 7:35. Prexy **Ted Tomita** was at his eloquent best as he thanked the members present and presented the panelists which included **Victor McKusick,** Professor of Medicine at Johns Hopkins; **Tague Chisholm,** Clinical Professor of Surgery at the University of Minnesota; **Georgiana Seegar Jones,** Associate Professor of Gynecology and OB at Johns Hopkins; **David Smith,** Associate Professor of Pediatrics, University of Washington; **Howard Jones,** Associate Professor of Gynecology and OB at Johns Hopkins; and **Virginia Apgar,** Director of Research, National Foundation. Or was it our hardworking Arrangements chairman, **Herbie Chinn** who presented them? The morning caffeine had not quite circulated by this time and our recollections are a bit fuzzy? We do remember a slightly alopecic **Victor McKusick** perfunctorily expounding a classical survey of genetic principles which is rather difficult to stomach at any hour. In the round table discussion that followed, we listened to robust, grey-haired, bubbling, rapid-fire speaker **Virginia Apgar** discuss the hereditary aspects of congenital disorders. How she tied in the story of the invention of the stethoscope with congenital disorders, we are at a loss to recall, but her version is that the ladies in the French courts got tickled by the beards of their physicians and raised a fuss. Copanelist **Tague Chisholm,** crewcut and boyish, remarked on the physician's reluctance to catheterize infants with the Gilbert & Sullivan soliloquy, "What, never? No, never! Never? Well . . . hardly ever!" He was trying to put across the point that the catheter is an important tool for diagnosing choanal atresias and imperforate ani.

Later that evening we returned to listen to suave **Dudley Seto** review the case for renal dialysis. We were interested to learn that the cost of dialysis has been reduced from $10,000 per year with the twin coils to $2,000 with the Maytag kidneys. **Georgiana Seegar Jones** did not disappoint us with her pleasant drawl, which took the edge off her highly technical paper on ovulation and made it pleasant to listen to and yet not comprehend. **Victor McKusick** concluded the evening with another informal presentation on the differential diagnosis of Marfan's syndrome and homocystinuria, which should be of tremendous benefit to us when and if we ever run across one.

We filed into the second morning session as charming **Phyliis Wright,** Director of the Birth Defect Center, presented her cases. A recording of the *cri du chat* syndrome (cat cry syndrome to us nonlinguists) sounded eerie in the darkened lecture room and chilled our dorsal spines. Phyllis was particularly sober as she presented a 24-year-old mother with a child with rubella syndrome and related how she had pleaded for a therapeutic abortion and had been refused by the doctor.

Internist **"Wini" Lee** discussed the clinical application of nuclear medicine in the evening session and covered the highlights of nuclear medicine. He made the candid remark, "In my prejudiced nonsurgical opinion, I feel that the thryoid scan is perfectly safe."

During the panel discussion on therapeutic abortions for congenital anomalies, **Tague Chisholm** seemed to echo the sentiments of most physicians faced with a

similar problem. "The decision to salvage a severely deformed child lies with the parents. I do not like to play God."

AMA President **Charles Hudson** feared that the audience would leave, but was reassured when **Herbie Chinn** announced that the free drinks through the courtesy of Aetna Life would be served after his speech. He pointed out that "to avoid the welfare state, physicians must take on responsibilities which they have not taken on before." He proposed that "we evaluate the quality of our services, discover needs before they are found by another, and expand those programs which would improve our services."

We arrived with some trepidation for the lecture "Pronouncement of Sex" by **Howard Jones**. Somehow though all the slides were reversed we could read them with some effort, but he finally got us with a Latin phrase in reverse. Howard emphasized that surgical correction for intersexes should be performed early, since the physician's vacillation could lead to problems. He presented slides of one Daniel, who left the hospital as Constance.

Ph.D. **Chin Sik Chung** gave a paper on "The Genetics of Club Feet." He delved into the high incidence of talipes equinovarus (TEV) among the Hawaiians, and was ecstatic as he showed with his statistics "the beautiful decrease of Hawaiian blood." Elsewhere he would have been condemned for spouting racism.

**Sam Waxman** dogmatically presented his paper, "Cytogenetics of Spontaneous Abortions." He reported that the average age as 28 and that Hawaiians had the greatest incidence of spontaneous abortions. He noted an estimated 10 to 40 or 45 per cent abnormal karyotypes in Hawaiians.

**Ian Shine,** a movie prototype of the typical Englishman, described Hawaii as an archipelago of multiracial families, ideal for genetic studies. He pointed out the defect of our constitution which stresses that "all men are created equal." "To the geneticist, this is not true. My paper is on racial inequality," he said.

**Victor McKusick** commented on hereditary vs. environmental influences in genetic counseling: "If the child looks like the father, then it is environmental and if it looks like the neighbor, it is hereditary." Wise philosopher and captivating medical lecturer **Tague Chisholm** ended his "Congenital Anomalies" with the oriental aphorism, "The head can only absorb as much as the fanny can withstand." With typical pediatric surgical optimism, he stated, "We do not talk about five-year survivals, but of 65-year survivals."

## HMA Golf Tournament

We were as light of heart as the other 80 hopefuls as we hastened to the Waialae Golf Course for the annual HMA Golf Tournament. **Tom Fujiwara,** like a good host, insisted we partake of a tall glass of beer before teeing off, but this was no excuse for the dribbling golf we played, for the weather was perfect, the fairways excellent, and the greens *par excellence*. Methodical **Roy Tanoue** could not err even if he tried, until the 14th hole. **Tom Fujiwara** lamented the state of his game and could not understand how his balls would accidentally land on the green and drop carelessly into the cup. Fortunately through Roy's generosity of a few extra strokes and **Y. Fukushima's** superb back-nine stand, we managed to flounder through without much damage. Smooth-swinging **Tommy Chang** in the back foursome came through in excellent shape as he shot a 78-9-69 to win the Gaspar Low Gross Trophy and Paul Tamura's Path Associate's gift certificate. But it took an inspired **Don Maruyama** playing his first HMA tournament to walk off with low net and the President's Trophy with a sparkling 80-14-66. **Wini Lee** was in 3rd place and won $50 worth of medical books while **Ralph Cloward** won the 4th place RCA clock radio. **Peter Kim** placed 5th, **Blue Nishigaya** was 6th, and **Francis Kaneshiro** 7th. Our dear friend **Tom Fujiwara** was in 8th place inspite of his bad day, and **Al Paraz** still playing with a 19 handicap placed 9th. Honest **Gil Freeman** with a dubious 27 handicap placed 10th. We, of course, received a consolation golf ball for our efforts. Well, there's always a next time, they say . . . And oh! how sour the grapes.

## HMA Tennis Tournament

Twenty-six stalwarts braved their wives' wrath and the hottest Mother's Day since 1961 to play in the 3rd Annual HMA Tennis Tournament. Seven doubles teams chose to play in the open tournament and six teams in the round robin series. We worried about **Cal Sia** who was involved in a car collision the night before, but were relieved to see him limp in with a badly bruised right knee. All players suffered from various degrees of low-salt syndrome and **Hunky Chun's** salt tablets were lifesaving. **Shig Horio** had to quit and nearly forfeited, but was revived by salt tablets and managed to finish the gruelling sets. **Fred Gilbert** ruptured either the plantaris or soleus and limped through his last set. When the scores were finally tallied, the duo of **Yutaka Yoshida** and **Leabert Fernandez** lived up to their pregame boasts and won by one point and close behind were **Ben Tom** and **Charley Ching.** Said 'Yosh' to Ben in the postgame session: "I'll play you left handed next year. Meanwhile, I want you to take some lessons this year." All in jest, of course.

In the round robin series, **Bruce Joseph** and partner **Fred Gilbert** (ruptured muscle and all) won with hands down while in second place were **Bill Goebert** and **Jordan Popper.**

## HMA Fishing Tournament

Unlike the golfers and tennis players, the fishermen have traditionally been uncommunicative about their feats, so much of the information had to be gleaned from Bruce Carter's column. Apparently four boats participated in the Sunday tournament "which produced a goodly number of medium-sized aku and ahi, but only one sizable fish" which was **Roy Kaye's** 34 pound ono. **Don Peck** won 2d place for most fish with five good aku. **Carl Lum** repeated his win for the smallest fish (incidentally, Carl has two large marine aquariums in his beautiful Ossipoff-designed home in Nuuanu and he may possibly be stocking his aquariums with these undersized catches). Church-goer **Francis Au** won the prize for the biggest fish story. How **Dick Sakimoto** fit into the tournament, we do not know, but he was also awarded a booby prize.

## Hors de Combat

Scholarly, soft-spoken, mild-mannered **Sam Allison** surprised us with yet another undisclosed facet of his variform personality, viz., a bulldog ferocity when aroused. In May, he surprised a sword wielding burglar in his home one afternoon and gave chase to the intruder even after being slashed on both legs, until a neighbor called attention to the bleeding. The thief was quickly apprehended and the sword returned to Sam's bedroom from whence it came. Sam's rescuer rushed him to Kaiser Hospital where he was treated and released after repairs. The injuries were described as minor, but we met him six weeks later still limping along with cane because of residual nerve damage from the deep sword slashes.

We seem to be a favorite target for burglars, judging from the frequency of physician victims: In April, burglars broke into **Mitsuo Kuramoto's** office, **Harold Sexton's** Hawaii-Kai drive home, and the offices of **Edmund Lum, Wilfred Kurashige, Bernard Fong,** and

*continued page 621*

# *Our New President*



Barrister Allen "Buster" Richardson, orthopedic surgeon and scion of a kamaaina Hawaiian Kona family, will have a firm hand on the helm of the Hawaii Medical Association for the coming year. It has been just 16 years since Duke Cho Choy and Lindy Chun proposed him for membership and Grover Batten, Sr., Louis Gaspar, and Mon Fah Chung approved his application.

They've been busy years for him. In addition to the demands of a flourishing orthopedic practice and a host of community activities culminating in the chairmanship of the State Board of Medical Examiners, of which he was a member from 1959 through 1965 (and is still a "lame duck" member) he has been continuously active in the Medical Association's committees — Legislative, Workmen's Compensation, Federal Medical Services, Medical Practice Act Revision, for the most part. He was Honolulu County Society President in 1964.

"Buster" was born in Honolulu, February 24, 1918, son of Arnold and Esther Richardson. The family moved to the Big Island before he reached high school, and he graduated from Hilo High in 1936 and from the University of Hawaii in 1940. He received his M.D. from Yale in 1943; interned in Montclair, N.J., and after three years of duty in the U.S. Army, which discharged him as a Major in 1947, had a residency and instructorship in orthopedic surgery at the University of Pennsylvania from 1947 to 1951, when he came home to practice.

On July 21, 1945, at Kawaiahao Church, he married Florence Elizabeth Ching, of Port Allen, Kauai; their son and daughter, Allen Barrister Mohiakalaniikeola and Allene Kaleimomi, are both in college now. Allen was a member of the All-American NCAA swimming and water polo teams.

In his specialty, "Buster" is a diplomate of the American Board of Orthopedic Surgery, a member of the Western Orthopedic Association, and a Fellow of the American Academy of Orthopedic Surgery and the American College of Surgeons. In the community, he is a Master Mason, a Shriner, member of the Scottish Rite, and a member of the Board of Directors of the Liliuokalani Trust.

He plays chess, cribbage, poker, and ping-pong, but his first love in hours off duty is golf—every Saturday afternoon at Waialae. He follows the Islanders and interscholastic football and basketball—cheering for Hilo High!—and has been team physician for the Kaimuki High football team for the past 12 years. ■

# *Presentations*



Varian Sloan presents Ted Tomita with annual Robins Award for Community Service.



Henry Yokoyama presents annual Journalism Awards to Pat Hunter and Robyn Rickard.



Ted Tomita gives Dean Windsor Cutting the second contribution from AMA-ERF to the University of Hawaii School of Medicine.

**HAWAII**
**MEDICAL**
**ASSOCIATION**

**111th Annual Meeting**
**May 17-20**
**Honolulu**

# *Our Presidents*



President Buster Richardson displays his badge of office, the Fractured Cane.



AMA President Charles Hudson receives the traditionally Hawaiian welcome from a Ka Palapala Queen.



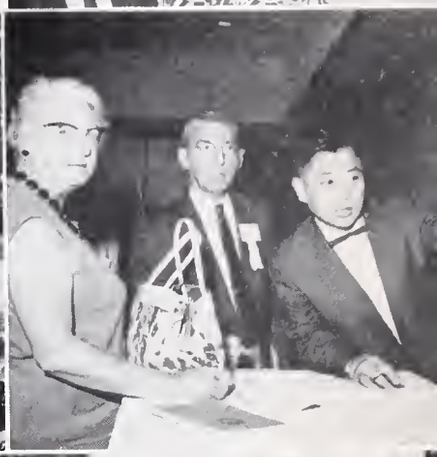
Retiring President Ted Tomita receives a plaque of appreciation from ex-President Al Burden.



President-elect Bob Miyamoto is surrounded by Ka Palapala Queens.





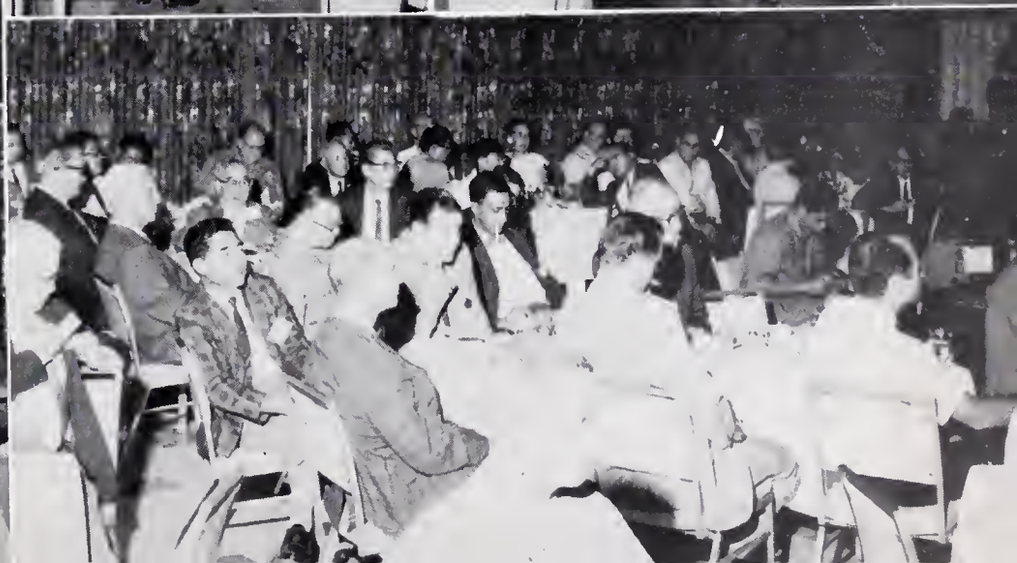





Coca-Cola





# 111th Annual Meeting
# Hawaii Medical Association

## HONOLULU, HAWAII

### May 17 through May 20

The annual meeting for the one hundred and eleventh year of corporate existence of the Hawaii Medical Association was held in Honolulu in 1967. The following program was presented:

## SCIENTIFIC PROGRAM

PANEL DISCUSSIONS

Therapeutic Abortions far Corgenital Anomalies

MODERATOR: Herbert Y. H. Chinn, M.D.
PANELISTS: Howard W. Jones, Jr., M.D.; David W. Smith, M.D.; Tague C. Chisholm, M.D.; Victor A. McKusick, M.D.; Virginia Apgar, M.D.; Georgianna Seegar Jones, M.D.

Genetic Counseling

MODERATOR: K. S. Tom, M.D.
PANELISTS: David W. Smith, M.D.; Victor A. McKusick, M.D.; Richard Blaisdell, M.D.; Stanley Wright, M.D.

CASE PRESENTATIONS

Presented by Phyllis Wright, M.D.
DISCUSSANTS: Howard W. Jones, Jr., M.D.; Tague C. Chisholm, M.D.; Virginia Apgar, M.D.

PAPERS

Genetics in the Practice of Medicine
Victor A. McKusick, M.D.
Effects of Dialysis
Dudley S. J. Seto, M.D.
Visible Surgical Anomolies in Infancy and Age of Chaice for Elective Surgery
Tague C. Chisholm, M.D.
Introduction of Ovulatian
Georgianna Seegar Jones, M.D.
Heritoble Disorders of Connective Tissues—Newer Concepts
Victor A. McKusick, M.D.
Clinical Application of Nucleor Medicine
Winfred Y. Lee, M.D.
Fetal Rubello Pothology
David W. Smith, M.D.
Address
Charles L. Hudson, M.D.
Pronouncement of Sex
Howard W. Jones, Jr., M.D.
The Genetics of Club Feet
Chin Sik Chung, Ph.D.
Cytogenetics of Fetol Abortions
Sorrell H. Waxman, M.D.
Genetics in Mental Retardation
Ian Shine, M.D.
Congenital Anomolies—What Price Salvage?
Tague C. Chisholm, M.D.

## SOCIAL PROGRAM

Sportsmen's Night, Waialae Country Club
Banquet, Ilikai Hotel

## MEETINGS

House of Delegates, Mabel Smyth Bldg.
Scientific Program, Princess Kaiulani Hotel
Woman's Auxiliary, Coconut Island

## PARTICIPATING DELEGATES

Hawaii Caunty:
R. P. Wipperman
Pete Okumoto

Kauai County:
W. W. Goodhue

Maui County:
Marion L. Hanlon
J. Mark B. Sowers

Honalulu County:
Edward W. Boone
Scott C. Brainard
Walter Y. M. Chang
Charles T. H. Ching
William W. L. Dang
Frederick A. Dodge
Thomas P. Frissell
George Goto
Casimer Jasinski
Robert T. S. Jim
Donald A. Jones
Robert Kim
Keith F. O. Kuhlman
Winfred Y. Lee
Carl Lum
Robert K. Mookini
Richard D. Moore
George H. Nip
Don E. Poulson
J. Frederick Reppun
William H. Sage
Clarence S. Sakai
Raymond M. Tamura
Benjamin C. K. Tom
Coolidge S. Wakai
Robert T. Wong

## REFERENCE COMMITTEES

Public Health
Marion L. Hanlon
*Chairman*
Donald A. Jones
Clarence S. Sakai
R. P. Wipperman

Insurance and Medical Service
Thomas P. Frissell
*Chairman*
Edward W. Boone
Pete T. Okumoto
J. I. F. Reppun
J. Mark B. Sowers

Miscelloneous Business
Winfred Y. Lee
*Chairman*
Charles T. H. Ching
Frederick A. Dodge
Benjamin C. K. Tom

Porliomentory Affoirs
Coolidge S. Wakai
*Chairman*
W. W. Goodhue
Robert T. S. Jim
Don E. Poulson

# Hawaii Medical Association
## Committees for 1966-67

### AMA-ERF Committee
Douglas B. Bell, II, Chairman
Clifford Chang
Jorge Froilan
Sorrell H. Waxman, Vice Chairman
George Bracher (Hawaii)
Billie Fern Strother (Maui)
Webster Boyden (Kauai)

### Arrangements Committee
Herbert Y. H. Chinn, Chairman
E. Robert Ballard (Exhibits)
Thomas Chang, Vice Chairman
Takeo Fujii (Golf)
Richard Omura (Picnic)
Herbert G. Pang
Dudley Seto (Fishing)
R. Varian Sloan
Yutaka Yoshida (Tennis)
Ed. B. Helms (Hawaii)
John Francis Morris (Maui)
Samuel Wallis (Kauai)

### Assoeiation of Professions Committee
George F. Schnack, Chairman
Edward Boone
Raymond deHay
Thomas P. Frissell
Thomas Lau
Rowlin Lichter
Donald C. Marshall
Ethel Oda
Noboru Oishi, Vice Chairman
Henry Yuen (Hawaii)
A. Y. Wong (Maui)
K. K. Fujii (Kauai)

### Automotive Safety Committee
Truett V. Bennett, Chairman
C. M. Burgess
James G. Harrison
Raymond Hiroshige, Vice Chairman
William J. Holmes
Carl Johnsen
Edmund C. K. Lum
James Matayoshi (Hawaii)
J. A. Burden (Maui)
Clyde Ishii (Kauai)

### Awards Committee
John J. Lowrey, Chairman
Robert T. S. Jim
Richard Omura
Herbert G. Pang
K. S. Tom
William Bergin (Hawaii)
G. Y. Tomoguchi (Hawaii), Vice Chairman
Francis Wong (Hawaii), Vice Chairman
James F. Fleming (Maui)
Burt O. Wade (Kauai)

### Bureau of Research and Planning
Samuel D. Allison, Chairman
Fred I. Gilbert
Frederick Giles
Robert T. S. Jim
Francis H. Fukunaga
Richard Kelley
Victor Mori
J. I. F. Reppun
Paul Tamura
Bernard Yim
H. E. Crawford (Hawaii)
Mamoru Tofukuji (Maui)
James R. Warner (Kauai)

### Bylaws & Parliamentary Committee
Francis T. C. Au, Chairman
Richard Ando, Vice Chairman
Harry L. Arnold, Jr.
Cesar B. DeJesus
Alexander Roth
H. E. Crawford (Hawaii)
J. A. Burden (Mauai)
Burt O. Wade (Kauai)

### Cancer Committee
Samuel D. Allison, Chairman
Philip S. Arthur
Grover H. Batten
John P. Clarkin
G. C. Freeman
Raymond H. Fujikami
Hans W. Graumann
Roy Iritani
Thomas Lau
Philip J. W. Lee
Wilbur S. Lummis
George Nip
Satoru Nishijima
Robert W. Peyton
Norman Sloan
C. J. Straehley
I. L. Tilden
George Bracher (Hawaii)
J. A. Mitchel (Hawaii)
L. S. Rockett (Maui), Vice Chairman
Robert J. Emrick (Kauai)

### Careers Committee
James B. H. Young, Chairman
Ann B. Catts
Louise Childs
H. W. Goebert
Masaru Koike
Donald C. Marshall
R. W. Noyes, Vice Chairman
Norman Sloan
Theodore Tseu
Bernice Walters
Harold Lewis (Hawaii)
J. A. Mitchel (Hawaii)
Robert Bjornsen (Maui)
Webster Boyden (Kauai)

### Chronie Illness and Aging Committee
Gordon Liu, Chairman
L. C. Beck
A. Kamsat
David Katsuki
Rowlin L. Lichter
Edmund C. K. Lum
Wilbur S. Lummis
A. V. Molyneux
Francis T. Oda
Noboru Oishi
David Lee Pang
Dudley Seto
R. Frederick Shepard
Patrick Walsh
Robert Miyamoto (Hawaii)
Pete Okumoto (Hawaii), Vice Chairman
Kenneth Haling (Maui)
Y. Miyashiro (Kauai)

### Communieable Disease and Immunization Committee
L. T. Chun, Chairman
Noberto Baysa
Frank J. Bruce
Ira Hirschy
George Kenessey
Joseph Oren
Betty Soo
John Jenkin (Hawaii)
Marion Hanlon (Maui)
Peter Kim (Kauai), Vice Chairman

### Crippled Children Committee
Victor Mori (1969), Chairman
Scott C. Brainard (1969)
Jeanette Chang (1968)
Herbert Y. H. Chinn (1967)
Ralph B. Cloward (1967)
Katherine J. Edgar (1967)
William H. Gulledge (1969), Vice Chairman
George Henry (1967)
Wallace W. S. Loui (1969)
Carl B. Mason (1969)
Frances Nakamura (1967)
Francis T. Oda (1969)
Richard K. S. Pang (1969)
R. Frederick Shepard (1967)
Coolidge Wakai (1967)
Paul Caldwell (Hawaii) (1969)
Ruth E. Oda (Hawaii) (1968)
Marion Hanlon (Maui) (1969)
M. A. Brennecke (Kauai) (1968)

### Diabetes Committee
Charles S. Brown, Chairman
George Kenessey
Winfred Y. Lee, Vice Chairman
Wilbur S. Lummis
Willard Miyahira
L. G. Stuhler
Kay Ota (Hawaii)
A. Y. Wong (Maui)
Peter Kim (Kauai)

### Disaster Committee
Casimer Jasinski, Chairman
Edward W. Boone
Roger Brault
H. H. Chun
Albert Chun-Hoon, Vice Chairman
William W. L. Dang
Fred Lam, Jr.
Mor J. McCarthy
Rodman B. Miller
H. C. Nordstrom
Walter B. Quisenberry
Livingston Wong
James Matayoshi (Hawaii)
Edward B. Underwood (Maui)
Samuel R. Wallis (Kauai)

### Federal Medical Services Committee
William Dang, Chairman
Grover H. Batten
Herbert Y. H. Chinn
George Goto
Gail Li
Chew Mung Lum
L. Q. Pang
Kazuo Teruya
Frederick B. Warshauer
R. P. Wipperman (Hawaii), Vice Chairman
William E. Iaconetti (Maui)
Burt O. Wade (Kauai)

### Fee Survey Committee
Frederick B. Warshauer, Chairman
Winfred Chang
Roy Kaye
John Krieger
Philip J. W. Lee
Carl Mason
Robert Mookini
O. D. Pinkerton, Vice Chairman
Don E. Poulson
Paul Tamura
John Watson
Harold Lewis (Hawaii)
William E. Iaconetti (Maui)
Peter Kim (Kauai)

### Hawaiian Academy of Science Committee
Robert A. Nordyke, Chairman
Charles C. Custer
Robert T. S. Jim, Vice Chairman
Paul F. McCallin
Donald A. Peck
Thomas H. Richert
Sorrell H. Waxman
Frank Tabrah (Hawaii)
Sakae Uehara (Maui)
Kenneth K. Fujii (Kauai)

### Heart Committee

Coolidge Wakai, Chairman
Morton E. Berk
Edward L. Chesne
Bernard Fong
Unoji Goto
George W. Henry
Wallace S. Loui
Wilbur Lummis
Richard Mamiya
Frances Nakamura
Richard Pang, Vice Chairman
Ed. B. Helms (Hawaii)
Bertram A. Weeks (Maui)
Peter Kim (Kauai)
John F. Chalmers
Philip T. Chu
Raymond deHay
P. H. Liljestrand
Carl H. Lum
Wilbur S. Lummis

### Hospital Committee

Keith F. O. Kuhlman, Chairman
David Bronder
Robert K. Mookini, Vice Chairman
Noboru Ogami
Harold M. Sexton
K. S. Tom
William H. Wilkinson
H. E. Crawford (Hawaii)
Harold Lewis (Hawaii)
Robert Miyamoto (Hawaii)
Joseph E. Andrews (Maui)
Yonemichi Miyashiro (Kauai)

### Indigent Medical Care Committee

Patrick Walsh, Chairman
Eleanore Akina
Grover H. Batten
John Devereux
Reginald Ho
Masaru Koike
Keith F. O. Kuhlman
Henry Manayan
John Ohtani
James A. Mitchel (Hawaii)
R. P. Wipperman (Hawaii)
Kenneth Haling (Maui)
P. M. Cockett (Kauai), Vice Chairman
Burt O. Wade (Kauai)

### Japanese Speakers Bureau

Kazushi Tanaka, Chairman
Noboru Akagi
Takakazu Fukumura
Keiichi Goshi
Harry Nakata
Shigeo Natori
K. Okazaki
F. Sugimoto
Perry T. Sumida
Y. Ushiyama
Henry Yokoyama, Vice Chairman
S. Kasamoto (Hawaii)
Lester T. Kashiwa (Maui)
Yonemichi Miyashiro (Kauai)

### Legislative Committee

George Goto, Chairman
Leo Bernstein
Etta Wright Best
John Chalmers
Clarence Chang
John Devereux
Eldon Dykes
Thomas Frissell
Keith F. O. Kuhlman, Vice Chairman
Richard K. C. Lee
Rowlin Lichter
Edmund C. K. Lum
K. Y. Lum
Alvin V. Majoska
George H. Mills
Joseph Nishimoto
L. Q. Pang
Robert Peyton
Walter Quisenberry
R. Frederick Shepard
Billie Fern Strother
Burt O. Wade
C. A. Wyatt
Robert Miyamoto (Hawaii)
J. Alfred Burden (Maui)
Yonemichi Miyashiro (Kauai)

### Maternal and Perinatal Mortality Study Committee

Francis M. Terada (1969), Chairman
Cora Au (1967)
Robert C. Bell (1967)
Samuel J. Buist (1967)
Ann B. Catts (1967)
Donald F. B. Char (1967)
Robert G. Dimler (1967)
Katherine J. Edgar (1967)
George Goto (1968)
William J. Hindle (1969)
Robert T. S. Jim (1967)
John Krieger (1968)
Frederick S. F. Lee (1967)
Paul F. McCallin (1968)
James L. Mertz (1967)
William A. Myers (1968)
Herbert M. Nakata (1969)
Joseph T. Nishimoto (1967)
Noboru Ogami (1967)
John M. Ohtani (1969)
Thomas K. Oshiro (1968)
Richard Y. Sakimoto (1967)
Millard Seto (1969)
Calvin C. J. Sia (1967)
David Sinclair (1969)
Betty Soo (1969)
Francis H. Soon (1967)
Grant N. Stemmermann (1967)
Edward Taras (1969)
Mitsuo Tottori (1967)
Theodore K. S. Tseu (1967)
Rodney T. West (1967)
James Wong (1967), Vice Chairman
Jack S. Woodruff (1967)
Paul J. Caldwell (Hawaii) (1968)
W. B. Patterson (Maui) (1968)
M. A. Brennecke (Kauai) (1968)

### Medical Care Plans and Fees Committee

George H. Mills, Chairman
Grover H. Batten
William W. L. Dang
Keith F. O. Kuhlman
Gail Li
John J. Lowrey
Chew Mung Lum, Vice Chairman
Carl Mason
Robert K. Mookini
L. Q. Pang
Robert W. Peyton
Don E. Poulson
Frederick B. Warshauer
William Bergin (Hawaii)
W. S. L. Loo (Hawaii)
James A. Mitchel (Hawaii)
Robert Miyamoto (Hawaii)
William E. Iaconetti (Maui)
Marvin Brennecke (Kauai)

### Medical Education Committee

Richard T. Mamiya, Chairman
Grover H. Batten
Donald F. B. Char
Ralph B. Cloward
Henry Fong
Raymond H. Fujikami
Lawrence H. Gordon
Gabriel Ma
Willard Miyahira
Satoru Nishijima, Vice Chairman
George F. Schnack
Harold M. Sexton
Francis Terada
Livingston Wong
Bernard Yim
George Bracher (Hawaii)
Frank Tabrah (Hawaii)
Billie Fern Strother (Maui)
R. J. Warner (Kauai)

### Medical Practice Act Committee

Keith F. O. Kuhlman, Chairman
Frank J. Bruce
John F. Chalmers
Robert Chung
Raymond deHay
Raymond Dusendschon
Thomas P. Frissell
Richard Omura
R. Frederick Shepard, Vice Chairman
Walter S. L. Loo (Hawaii)
Robert Miyamoto (Hawaii)
Seiya Ohata (Maui)
Y. Miyashiro (Kauai)

### Medicine and Religion Committee

Duke Cho Choy, Chairman
Ann Catts, Vice Chairman
Claude V. Caver
Theresia Graumann
Tadao Hata
Shigeru Horio
Maurice Howell
Harold Lawson
Francis Soon
Sau Ki Wong
R. T. Eklund (Hawaii)
J. A. Mitchel (Hawaii)
J. Mark B. Sowers (Maui)
R. J. Warner (Kauai)

### Mental Health Committee

K. Y. Lum, Chairman
Robert Bell
Elmars Bitte
Kenneth Christensen
William Cody, Vice Chairman
H. Wm. Goebert
Theresia H. Graumann
Audrey W. Mertz
William A. Myers
F. S. Popoff
George F. Schnack
J. Kendall Wallis
Robert Weiner
William Won
Charles Belcher (Hawaii)
George Bracher (Hawaii)
Charles W. Stewart (Maui)
James R. Warner (Kauai)

### Message of the Month Committee

William F. Moore, Jr., Chairman
Gail Li
Kazuo Teruya
William Won
Edward Yamada, Vice Chairman
William Bergin (Hawaii)
Milton Howell (Maui)
Robert Emrick (Kauai)

### National Legislation Committee

L. Q. Pang, Chairman
Homer Benson
Scott Brainard
Bernard Fong, Vice Chairman
T. Fujii
Richard K. C. Lee
Joseph Nishimoto
E. Lee Simmons
Chisato Hayashi (Hawaii)
Clifford Moran (Maui)
Y. Miyashiro (Kauai)

### Negotiating Committee

Chew Mung Lum, Chairman
Grover H. Batten
Don E. Poulson, Vice Chairman
Rodney T. West
William Bergin (Hawaii)
William E. Iaconetti (Maui)
Yonemichi Miyashiro (Kauai)

### News Media Committee

Henry Yokoyama, Chairman
Morton Berk
Donald Char
Herbert Y. H. Chinn
Henry Fong
Carl Lum
Victor Mori
Satoru Nishijima
R. W. Noyes
Robert Peyton
Alexander Roth
Calvin Sia
Paul Tamura
Benjamin Tom, Vice Chairman
Edward Yamada
William Bergin (Hawaii)
Milton M. Howell (Maui)
R. J. Warner (Kauai)

### Nominating Committee

Charles S. Brown, Chairman
Robert P. C. Ho
J. I. F. Reppun
R. F. Shepard
Coolidge S. Wakai
Robert Miyamoto (Hawaii)
Clifford F. Moran (Maui)
Burt O. Wade (Kauai)

### Nurses Liaison Committee

Robert G. Hunter, Chairman
Ann B. Catts
H. H. Chun
William G. Davis
A. V. Molyneux
A. L. Vasconcellos, Vice Chairman
Etta Wright Best (Hawaii)
William B. Patterson (Maui)
Clyde H. Ishii (Kauai)

### Operation Pacific Committee

Thomas H. Richert, Chairman
Edward W. Boone, Vice Chairman
William J. Holmes
Rene Joyeuse
Lawrence H. Winter
William Bergin (Hawaii)
Milton Howell (Maui)
Patrick Cockett (Kauai)

### Pension and Investment Committee

Raymond C. Yap, Chairman
Marcelino J. Aveeilla, Vice Chairman
Frank J. Bruce
Claude V. Caver
Herbert Y. H. Chinn
Elmer Johnson
Clarence Sugihara
I. L. Tilden
Paul Caldwell (Hawaii)
Guy Haywood (Maui)
M. A. Brennecke (Kauai)

### Pharmacy Committee

John F. Chalmers, Chairman
James J. Ball
Frederick Lee
Wayne S. Limber
Daniel Palmer
George Suzuki, Vice Chairman
Timothy Wee
Sau Ki Wong
Warren Wong
Harold Lewis (Hawaii)
K. Izumi (Maui)
R. J. Warner (Kauai)

### Publications Committee

Eldon Dykes, Chairman
Harry L. Arnold, Jr., Vice Chairman
C. M. Burgess
Donald A. Peck
F. S. Popoff
Frank L. Tabrah (Hawaii)
Frank A. St. Sure (Maui)
Patrick M. Cockett (Kauai)

### Public Relations Committee

Andrew C. Ivy, Jr., Chairman
Harry L. Arnold, Jr. (Ex Officio)
H. William Goebert, Vice Chairman
Toru Nishigaya
Thomas H. Richert
Benjamin Tom
Patrick Walsh
Henry Yokoyama
William Bergin (Hawaii)
Milton Howell (Maui)
W. W. Goodhue (Kauai)

### Quackery Committee

William Sage, Chairman
Truett Bennett
Richard Dang
Frederick Dodge, Vice Chairman
Carl Lum
William Natoli
Hideo Oshiro
Lawrence Winter
Ed. Helms (Hawaii)
Harold S. Kushi (Maui)
Robert Emrick (Kauai)

### Radiation Committee

William J. Natoli, Chairman
Philip S. Arthur
Thomas C. Brown
Hans W. Graumann, Vice Chairman
George Henry
Philip J. W. Lee
Winfred Y. Lee
Grover J. Liese
Robert G. Rigler
G. L. Yeoh
George Bracher (Hawaii)
Robert Bjornsen (Maui)
Robert Emrick (Kauai)

### Review Committee

Rodney T. West, Chairman
Kenneth Chinn, Vice Chairman
Albert Chun-Hoon
Raymond deHay
Roy Iritani
Herbert G. Pang
Hideo Oshiro
R. Varian Sloan
Tom Taira
Raymond T. Eklund (Hawaii)
Marion Hanlon (Maui)
W. W. Goodhue (Kauai)

### School Health Committee

Calvin C. J. Sia, Chairman
James J. Ball
Noberto Baysa
Donald F. B. Char
L. T. Chun, Vice Chairman
Richard Dang
Katherine J. Edgar
F. J. Lafferty
Wallace W. S. Loui
Edmund C. K. Lum
Donald C. Marshall
Audrey W. Mertz
Betty Soo
Ruth Oda (Hawaii)
Marion Hanlon (Maui)
Clyde Ishii (Kauai)

### Scientific Program Committee

Robert P. C. Ho, Chairman
Herbert Y. H. Chinn
Ralph B. Cloward
Fred I. Gilbert, Vice Chairman
Reginald Ho
Robert T. S. Jim
George Kenessey
Winfred Y. Lee
R. Varian Sloan
K. S. Tom
Sorrell H. Waxman
Livingston Wong
Etta Wright Best (Hawaii)
John Francis Morris (Maui)
Robert Emrick (Kauai)

### Television-Radio Committee

Benjamin Tom, Chairman
Barton R. Becker
Murray Berger
Walter Y. M. Chang
Albert Chun-Hoon
Frederick Lee
Grover J. Liese
George Nip, Vice Chairman
Robert W. Peyton
Alexander Roth
Shigemi Sugiki
Theodore K. L. Tseu
Herbert Uemura
Henry Yokoyama
William Bergin (Hawaii)
Milton M. Howell (Maui)
W. W. Goodhue (Kauai)

### Tuberculosis Committee

James J. Ball, Chairman
L. Clagett Beck
Wallace W. S. Loui
Robert H. Marks
Richard Pang
Robert Weiner
J. A. Mitchel (Hawaii), Vice Chairman
Edmund Tompkins (Maui)
Peter Kim (Kauai)

### Venereal Disease Committee

Robert Kim, Chairman
Murray S. Berger
Claude V. Caver, Vice Chairman
Cesar B. DeJesus
Ira Hirschy
W. H. Kurashige
E. Lee Simmons
S. Kasamoto (Hawaii)
Jose L. Romero (Maui)
Peter Kim (Kauai)

### Water Safety Committee

Elmars Bitte, Chairman
Roger Brault
C. M. Burgess
Casimer Jasinski
George Kenessey
Thomas H. Richert
Robert Smith, Vice Chairman
Paul Caldwell (Hawaii)
W. G. Pfaeltzer (Maui)
W. W. Goodhue (Kauai)

### Woman's Auxiliary Committee

K. S. Tom, Chairman
P. M. Corboy
Bernice Walters
Charles Yamashiro
R. T. Eklund (Hawaii)
James Fleming (Maui)
K. K. Fujii (Kauai), Vice Chairman

### Workmen's Compensation Committee

Don E. Poulson, Chairman
Thomas P. Frissell
Herbert Luke
Gabriel Ma
Herbert G. Pang
Richard Pang, Vice Chairman
R. Frederick Shepard
J. A. Mitchel (Hawaii)
L. S. Rockett (Maui)
W. W. Goodhue (Kauai)

### Ad Hoc Committee on Inhospital Medical Education

Richard T. Mamiya, M.D., Chairman
William W. Dang
Reginald Ho
Keith F. O. Kuhlman
John J. Lowrey
John Ohtani
Francis Terada
K. S. Tom
Bernard Yim

### Mabel Smyth

Donald C. Marshall.....Dec. 31, 1967
O. D. Pinkerton.....Dec. 31, 1969
John J. Lowrey (alt.).....Dec. 31, 1967

## SPECIAL APPOINTMENTS

Examining Board for Hansen's Disease—Wilfred Kurashige
Interprofessional Coordination—Leabert R. Fernandez, Theodore T. Tomita
Medical Advisory Committee to the University of Hawaii's Student Health Services—Bernard Fong
Medical Advisory Committee to DSS—Clifford T. Druecker, George H. Mills, Calvin Sia,
Keith F. O. Kuhlman, William N. Bergin, J. Alfred Burden, Patrick M. Cockett
State Employees' Retirement Plan Review Board—Grover H. Batten, Thomas S. Bennett, C. M. Lum,
Don Poulson, Francis Oda, William Won, Coolidge Wakai, Albert Chun-Hoon
Inter-Society Science Education Council—Robert A. Nordyke
University of Hawaii Environmental Poison Study Committee—Richard K. B. Ho
Department of Health Radiation Advisory Committee—Robert A. Nordyke
Anti-Smoking Program—Calvin Sia
HFPC Medical Center Action Committee—George Goto
Hawaii Curriculum Center—Richard T. Mamiya
State Commission on Children and Youth liaison with Maternal & Perinatal Mortality
Study Committee—Roy M. Kaye
State Commission on Hospitals—Toru Nishigaya
Inter-Industry Workmen's Compensation Study Committee—Don Poulson
Heart Program—Coolidge S. Wakai
Honolulu Mental Retardation Coordinating Committee—George Goto
The National Foundation's Health Scholarship Committee—C. M. Burgess

# PROCEEDINGS OF THE HOUSE OF DELEGATES

### 111th Annual Meeting of the Hawaii Medical Association

The first session of the House of Delegates of the Hawaii Medical Association was called to order by the President, Theodore T. Tomita, at 1:00 P.M., May 17, 1967, in the Mabel Smyth Auditorium, Honolulu.

Present were (officers) Theodore T. Tomita, B. A. Richardson, R. Varian Sloan, Herbert Y. H. Chinn; (county presidents) George H. Mills, Burt O. Wade, Etta Wright Best, Billie Fern Strother; (councillors) Robert M. Miyamoto, Grover H. Batten, Bernard W. D. Fong, Samuel R. Wallis.

(Honolulu delegates) Edward W. Boone, Scott C. Brainard, Walter Y. M. Chang, Charles T. H. Ching, William W. L. Dang, Thomas P. Frissell, George Goto, Robert T. S. Jim, Keith F. O. Kuhlman, Winfred Y. Lee, Carl Lum, Robert K. Mookini, Richard D. Moore, George H. Nip, Don E. Poulson, J. Frederick Reppun, Clarence S. Sakai, Raymond M. Tamura, Coolidge S. Wakai, Robert T. Wong; (Kauai delegates) W. W. Goodhue; (Hawaii delegate) R. P. Wipperman.

Honolulu President George H. Mills asked that the following alternate delegates be seated to complete Honolulu County's delegation: Benjamin C. K. Tom for Robert P. C. Ho (deceased), Casimer Jasinski for Gordon Liu, Frederick Dodge for R. Frederick Shepard, Donald A. Jones for Walter S. Strode, William Sage for Carolina D. Wong.

Maui President Billie Fern Strother asked that alternate delegate J. Mark B. Sowers be seated for Clifford F. Moran.

Hawaii President Etta Wright Best asked that Pete T. Okumoto be seated for Harold Lewis. No alternate was seated for the other absent delegate.

The minutes of the May 11-15, 1966, meeting were approved as published.

The reports of the President, Secretary, and Treasurer as well as those of Hawaii, Honolulu, Maui, and Kauai County Societies were in the Delegates' Handbook and were referred as indicated. The reports of the standing and special committees were referred to the reference committees as previously announced.

Dr. Richard Ando was appointed Parliamentarian.

The titles and resolves of resolutions 19, 20, 21, 22, 23, and 24 were read. Resolutions numbers 19 and 20 were referred to the Reference Committee on Parliamentary Affairs; resolutions numbers 21 and 24 were referred to the Reference Committee on Insurance and Medical Service; and resolutions numbers 22 and 23 were referred to the Reference Committee on Miscellaneous Business.

### RESOLUTION NO. 9

Re: In Memoriam of Robert P. C. Ho, M.D.

WHEREAS, The sudden and premature death of Dr. Robert P. C. Ho on January 13, 1967, which on personal grounds has brought sorrow to the hearts of a multitude of friends, is to the Hawaii Medical Assoication an inestimable loss; and

WHEREAS, Dr. Ho in his short lifetime conferred distinction on the entire medical profession through his intelligence, firmness, fairness, judgment, integrity, diligence, and achievement in both medical and nonmedical fields; and

WHEREAS, Dr. Ho undertook all tasks no matter how difficult with the perspicacity which enabled him to carry these tasks through to a satisfactory outcome; and

WHEREAS, The outstanding scientific programs the physicians of Hawaii have enjoyed over the past several years were due to the untiring efforts of Dr. Ho; and

WHEREAS, The scientific program for this year's annual meeting was designed prior to Dr. Ho's untimely death and carries the unmistakable mark of his brilliant and resourceful mind; now, therefore be it

*Resolved,* That the House of Delegates dedicate this 111th Annual Meeting of the Hawaii Medical Association to the memory of the man whose constant kindness, generous and affectionate consideration, and devotion to duty made possible the program we are privileged to enjoy this week, Dr. Robert P. C. Ho.

Submitted by THEODORE T. TOMITA, M.D.

**ACTION:**

**It was voted that Resolution Number 9 be adopted by acclamation and that it not be referred to a Reference Committee.**

The House recognized three past presidents who were president—Harry L. Arnold, Jr., Robert Faus, and Clarence Fronk.

* * *

The Reference Committees were in session May 17 beginning at 1:30 P.M.

* * *

The second session of the House of Delegates was called to order on Thursday, May 18, 1967, at 1:00 P.M. The Secretary called the roll. The following members who were seated on Wednesday were absent due to emergency—Scott Brainard and George Nip. The Honolulu President was asked if he would like to seat any alternates at that time. No alternates were seated. Samuel R. Wallis was also absent at the second session.

The President of the AMA, Charles L. Hudson, addressed the House of Delegates.

# REPORT OF REFERENCE COMMITTEE ON PUBLIC HEALTH

Mr. President and Members of the House of Delegates:

Your Reference Committee met before an audience of approximately 12 physicians and guests and received testimony on the various resolutions and reports submitted to the Committee for consideration and recommendation. Having heard the discussion of the witnesses and having given careful consideration to all the testimony presented to it, your Reference Committee is pleased to make the following report:

### AUTOMOTIVE SAFETY COMMITTEE

The definition of the function of the committee as proposed for the bylaws is thought to be well expressed and adequate. It is as follows: ". . . shall study legislation pertaining to the health aspects of automotive safety and make its recommendations to the Legislative Committee. It shall work with other traffic safety committees, assist the Public Utilities Commission on physical examination standards for drivers, and shall keep the Legislative Committee informed of legislative proposals on which the Association may take a stand."

During the past year the committee has (1) kept abreast of prevalent thinking and statistics in automotive safety in order to act intelligently in its advisory capacity; (2) kept track of current legislation; (3) supported legislation related to alcohol testing (implied consent law) and periodic relicensing and eye examinations; and (4) prepared a guide for "medical evaluation for vehicular driving." The committee is to the point of considering this guide closely and deciding upon recommendations as to the mechanism of applying it. The preliminary opinion is that the number of accidents caused by strictly medical reasons other than alcoholism is small and that the effort involved in periodic complete examination of each licensee would be out of proportion to the small number of accidents prevented. However, each physician should be encouraged to report to the Licensing Bureau any person known to be a dangerous driver because of medical reasons. More specific recommendations along this line should be considered in future meetings.

Automobile deaths are reaching alarming proportions and within ten years will reach 100,000 per year unless things are changed. Very important steps are being taken

through recent Federal legislation and current State legislation, and the Automobile Safety Committee can be of great importance in its advisory capacity.

RECOMMENDATIONS: (1) It is recommended that the committee be continued along the same lines and functions as at present.

TRUETT V. BENNETT, M.D.

*Auto Safety Committee*

Your Reference Committee first considered the report of the Auto Safety Committee and expresses its appreciation for the work of this committee. Considering the legal rights of the patient, your Reference Committee feels that paragraph 2, line 15, should be amended to read: "However, each physician should be encouraged to report to the Licensing Bureau with the patient's written consent any person known to be a dangerous driver because of medical reasons."

Your Reference Committee recommends that this report be accepted as amended.

Your Reference Committee further recommends that the Hawaii Medical Association seek legislation that would make physical or emotional disabilities which might make driving hazardous be reportable by law.

**ACTION:**

**The Chairman moved adoption of this portion of the report. It was adopted.**

## CANCER COMMITTEE

The Bylaws and Parliamentary Committee recommended last year that the Cancer Committee "shall be concerned with all matters relating to cancer control programs, consult with agencies such as the American Cancer Society, advise and supervise the Hawaii Cancer Commission and its Tumor Registry, and shall receive an annual report from that Commission for transmittal to the House of Delegates."

The President directed the Cancer Committee to concern itself with the Cancer Commission and the Hawaii Tumor Registry, the Cytological Program subsidized by the Department of Health, and the Anti-Smoking Program in the schools.

The Cancer Committee met several times during the year. Considerable time was devoted to the role of the Cancer Commission and the Hawaii Tumor Registry. An apparently amicable solution has been arrived at regarding the Registry, which is now nearly wholly subsidized by Federal Cancer Grants to the State Department of Health. It is agreed that the Department of Health has "the day-to-day" administration of the Tumor Registry. Policies are determined by the Commission (made up of members from the HMA, American Cancer Society, and Department of Health), and the Department of Health sees that these policies are executed. This policy was arrived at during the administration of Dr. Bernstein and there has been as yet no indication that changes in this relationship will be suggested under the administration of Dr. Quisenberry. A copy of the Cancer Commission's report is transmitted herewith.

The Cytology Program, which met with criticism at the last House of Delegates' meeting was studied. There seems to be no impelling reason to change the present free enterprise system. The Committee does feel, however, that all individuals who cannot readily afford private care should have services available to them and voted to approve the idea of the government's paying for cytologic examination for the indigent and medically indigent.

The Committee reviewed the Anti-Smoking Program in the schools. There is need for further expansion of this program.

The Committee was informed of the functions of the American Cancer Society. It approved a contemplated Oral Cancer Demonstration Program to be held next summer in cooperation with the American Cancer Society and Dental Association. The Committee also met jointly with the Scientific Program Committee regarding the Hawaii Medical Association's Scientific Session. Speakers who were to appear on the program to speak on cancer subsequently advised they would not be able to attend.

RECOMMENDATIONS: (1) That the Hawaii Medical Association play a stronger role in the Interagency Committee on Smoking. (2) That next year's committee develop a position paper on smoking along the lines of the California Medical Association's paper.

SAMUEL D. ALLISON, M.D.

REPORT OF THE CANCER COMMISSION

During the past year, the Cancer Commission held several formal meetings. In addition there were many informal sessions held by the Chairman with the Tumor Registry staff.

The activities of the Registry included (1) helping several hospital registries catch up with their backload of cases; and (2) preparing a five-year report of cases accumulated in the Registry during the years 1960-64. This report is expected to be ready for presentation at the time of the Annual Meeting of the Hawaii Medical Association.

The Registry staff was somewhat hampered by personnel shortage but despite this work progressed satisfactorily. To help alleviate the situation, part-time help was obtained. It was funded with Registry money which had been contributed by the Hawaii Division, American Cancer Society.

Immediately after completion of the five-year report, the Commission plans to have it published.

The American College of Surgeons' Field Representative for its Cancer Regionalization Program inspected the various cancer programs in Hawaii the first part of this year. He was favorably impressed with the Hawaii Tumor Registry. It is expected that the Hawaii Tumor Registry will receive the approval of the American College of Surgeons.

The State Chairman (Hawaii) of the Cancer Regionalization Program of the American College of Surgeons is planning a workshop for cancer program personnel (both staff, lay, and professional volunteers). The Cancer Commission has voted to participate and has also asked the American College of Surgeons' National Consultant to inspect the Hawaii Tumor Registry and consult with the Commission. Latest information from the American College of Surgeons' National Office is that they expect to be able to fund the workshop and provide the services of their Consultant. It is anticipated that the workshop will be held early this summer.

As the Hawaii Tumor Registry becomes older, it is becoming more valuable as a health service and research tool.

GROVER H. BATTEN, M.D.

*Cancer Committee*

Your Reference Committee next considered the report of the Cancer Committee. After consideration of the report, plus added information supplied by Dr. Grover H. Batten, your Reference Committee recommends that this report be accepted and commends the committee for its efforts in the fight against cancer. Your Reference Committee especially commends Dr. Batten for his tireless efforts on behalf of the Cancer Commission over a period of many years.

**ACTION:**

**The Chairman moved adoption of this portion of the report. It was adopted.**

## COMMUNICABLE DISEASE & IMMUNIZATION COMMITTEE

The committee urged that the Legislature do away with the requirement for typhoid-paratyphoid immunization. This was endorsed by the Honolulu Pediatric Society and the Hawaii Academy of General Practice. The Department of Health has introduced a bill to the legislature to amend Part II, Chapter 49, Revised Laws of Hawaii 1955, which will make it possible to do away with compulsory typhoid-paratyphoid immunization. The committee approved the subsequent amendment inserted at the request of certain religious groups.

The committee also approved the setting up of a clinic for free measles vaccine in the low-income-group area. The committee has been asked to work with the USC group in promoting an immunization seminar next August.

With Dr. Ira Hirschy on the committee, our relationship with the Department of Health has been very good and we should continue our communication with them in all matters regarding control of communicable diseases and immunization procedures.

RECOMMENDATIONS: (1) That the Hawaii Medical Association go on record as favoring routine use of live measles vaccine in the outpatient departments of the Honolulu hospitals for clients of the Department of Social Services, and that the Association exert every effort to see that this preventive measure is adopted. (2) That the Hawaii Medical Association adopt the position that in view of the contraindications and side effects, a doctor/patient relationship is desirable in the administration of measles vaccine. Therefore, mass immunization programs are not advisable in this State where there is a high incidence of tuberculosis.

L. T. CHUN, M.D.

*Communicable Disease and Immunization Committee*

Your Reference Committee next considered the report of the Communicable Disease and Immunization Committee. This committee has been an active committee and has worked well with the Department of Health and should be commended for its activities. Your Reference Committee recommends acceptance of this report.

**ACTION:**

**The Chairman moved adoption of this portion of the report. It was adopted.**

## CRIPPLED CHILDREN COMMITTEE

The committee met once, on October 25, to review recent changes and additions to the structure of the Crippled Children's Branch of the Department of Health. Eligible care includes such conditions as congenital heart diseases and rheumatic fever, cerebral palsy and mental retardation, orthopedic service, cleft lip and palate, eye defects, external congenital anomalies, disorders of communication, epilepsy, plastic surgery services, hearing defect, hernia, hypertrophied tonsils, thermal burns, etc. Some of the committee members requested information concerning the handling of consultation and distribution of patients.

The committee decided to act on call for any specific problems or complaints which were brought to the attention of this committee during the year.

RECOMMENDATIONS: The function of this committee has been curtailed by several factors. This committee formerly dealt with fee schedule. This function has now been transferred to the Negotiating Committee. The executive officer of the Children's Health Services Division has felt that some of the queries were an unnecessary intrusion into the affairs of the government. Doctors have expressed discontent, but did not file formal complaint to this committee.

This committee did not find reason to meet during the twelve months of the previous year. Since approximately fifty per cent of the funding of this agency comes from the Federal Government, this committee should probably be incorporated into the various committees of the Commission on Medical Services.

VICTOR M. MORI, M.D.

*Crippled Children Committee*

Your Reference Committee next considered the report of the Crippled Children Committee. Your Reference Committee feels that this committee report suggests areas that require serious consideration. Your Reference Committee recommends that this report be accepted but that the recommendation be amended to read that this committee continue in existence and be composed of individuals actively interested in the activities of the Crippled Children's Branch of the Department of Health and we further recommend that this committee be utilized in an advisory capacity by the Department of Health.

**ACTION:**

**The Chairman moved adoption of this portion of the report. It was adopted.**

## DIABETES COMMITTEE

The committee again sponsored the Diabetes Detection Program under the direct supervision of each County, and the reports to date are as follows:

*Oahu County:* (Dr. Winfred Lee, Chairman)—4,789 screened with 219 positive screenees but no final report as yet on the number of true positive diabetics.

*Kauai County:* (Peter Kim, M.D., Chairman)—Total number screened not given; new diabetics discovered, 104.

*Maui County:* Island of Maui—1,165 screened; 15 new diabetics discovered. Island of Molokai—643 screened; 16 new diabetics.

*Hawaii County:* (Walter S. L. Loo, M.D., Chairman)—Screening tests to be conducted this May.

The Department of Health again contributed much help, especially on the neighbor islands.

In summary, 135 new diabetics were discovered with the largest County not yet reporting its new diabetics because failure of individual doctors to report promptly.

Under the initiative of Dr. Willard Miyahira, considerable progress has been made toward the establishment of a summer camp for diabetic children. It is hoped that a camp will be in operation by the summer of 1968. There are 72 diabetic children in Hawaii, according to a recent poll conducted by the HMA, eight in the 1-5 age group, 18 in the 6-9 age group, and 46 in the 9-15 age group.

This committee unanimously disagrees with the recommendation of Dr. John R. Stephenson, Chairman of the Commission on Public Health, that it should be abolished and placed under the Chronic Illness and Aging Committee. Reasons are many and this chairman would be glad to present them to the House of Delegates.

BUDGET REQUEST: Incidental Expenses $300.

CHARLES S. BROWN, M.D.

*Diabetes Committee*

Your Reference Committee then considered the report of the Diabetes Committee. Your Reference Committee commends the work that is being done by the Committee in the detection of diabetes throughout the State. Your Reference Committee recommends that this report be accepted.

Your Reference Committee noted that no funds were expended by this committee during the past year. Your Reference Committee also feels the incidental expenses incurred in diabetes detection on the county level might well be considered legitimate expenses of the county medical societies. Therefore, your Reference Committee recommends that the budget request of $300 not be approved.

**ACTION:**

**The Chairman moved adoption of this portion of the report. It was adopted.**

## HEART COMMITTEE

At the request of the Hawaii Heart Association the committee met in January, 1967, to review and evaluate the proposed minimum standards for cardiovascular clinics in Hawaii as modified by the Hawaii Heart Association in June, 1965. A copy of the minimum standards was distributed to each member of the committee prior to the meeting and the pertinent items discussed. Since time did not permit review of the minimum standards in detail at this meeting a subcommittee consisting of Drs. Frances Nakamura, Bernard Fong, and Edward Chesne was selected for a more critical review. It was the recommendation of the subcommittee that "the Heart Committee accept in toto these minimum standards."

This committee agreed in principle that the HMA should stand behind these standards and agree in general with the criteria set forth by the Hawaii Heart Association for cardiovascular clinics. The rationale is that the support of these principles will indicate that there is no need for additional government clinics in this area. By these standards the two clinics of the CCS at Children's Hospital and The Queen's Hospital would be able to qualify. Certification of clinics is voluntary and that each clinic must ask to be certified.

It was voted to accept the recommendation of the subcommittee, and this recommendation was approved by the HMA Council.

The National Institute of Health is conducting a National C.D.P. The Straub Medical Research Institute is participating in this project and the Medical Director, Dr. Fred Gilbert, requested that the HMA review the protocol and approve the project.

The objective of this project is to test several drugs on long-term basis in men between the ages of 30-64 with previous proven myocardial infarction as to (1) reduction in mortality, (2) recurrence of myocardial infarction, etc., (3) relationship of cholesterol level with morbidity, mortality, etc.

Any physician wishing to have his patient participate in this program may contact the director of the Straub Medical Research Institute. A discussion was held on the value of drug study programs and also the legal implication that may be involved. This committee felt that what was wanted from the Hawaii Medical Association was a statement so that participating physicians could have the assurance that this was a legitimate and ethical study.

It was voted that the committee go on record as backing Dr. Gilbert in the drug study project. The council subsequently approved the committee's stand.

RECOMMENDATIONS: (1) That the House of Delegates reconfirm the committee's recommendations as approved by the council.

COOLIDGE S. WAKAI, M.D.

*Heart Committee*

Your Reference Committee next considered the report of the Heart Committee, and commends the committee for its work. Your Reference Committee recommends acceptance of this report.

**ACTION:**

**The Chairman moved adoption of this portion of the report. It was adopted.**

## MATERNAL & PERINATAL MORTALITY STUDY COMMITTEE

This committee studied in detail four maternal deaths. In addition, its subcommittee, under the chairmanship of Dr. Roy Kaye, studied ten perinatal deaths, three of which were discussed in greater detail at the monthly meetings of the over-all committee.

The first maternal death occurred after premature delivery of a stillborn infant and was due to mucoviscidosis with chronic bronchiectasis and bronchopneumonia. Death was classified as indirectly obstetrical and not preventable. The second maternal death occurred suddenly two weeks postpartum and the patient was brought to the hospital D.O.A. Cause of death was unknown and the case was unclassified because of incomplete autopsy. The committee expressed deep concern over the poor judgment displayed by the medical examiner in not studying the brain of this patient when no definite cause of death could be demonstrated by gross examination of the organs removed, and also of making a preconceived diagnosis without the benefit of an adequate history. The third maternal death was due to cardiovascular renal disease in a woman with a history of 20 pregnancies. Death occurred postpartum and was classified indirectly obstetrical and possibly preventable. The fourth maternal death occurred two months postpartum from a severe asthmatic attack which was felt to be unrelated to her pregnancy.

A fifth maternal death was discussed at the last meeting. The patient was a young cardiac patient of 29-week gestation who was brought to the hospital D.O.A. Death was probably due to rheumatic valvular heart disease. Because the private physician agreed to sign the death certificate even though he had not seen her for seven weeks and even though the terminal events leading to her demise were completely unknown, no autopsy was performed. The committee felt that both the physician and patient were responsible but the case was unclassifiable.

The members of this committee endorsed the changes made in the PKU rules and regulations by the Director of Health on the recommendation of the Board of Health. The changes were as follows: (1) Prematures will be tested only once, after 24 hours of milk feeding and before 14 days of life. (Previously they were tested at five days of life and again at the time of discharge from the hospital or at 14 days of life, whichever came first.) (2) All PKU testing will be done by private laboratories approved by the Department of Health for such testing and no tests will be run by the Department of Health.

Dr. Jack Woodruff represented this committee at the AMA's National Conference on Infant Mortality held August, 1966, in San Francisco. Dr. Woodruff provided the committee with a report of the meeting upon his return. Conclusions drawn by the participants of the conference were that identification and treatment of the higher risk mother prior to pregnancy, particularly among the nonwhite and indigent segments of the population, are the key to further reduction of the U.S. infant mortality rate. Particular emphasis must be given to a comprehensive program to reduce prematurity through expanded programs of interconceptional and preconceptional care. Such a program to be successful would require increased group health education to accelerate understanding and motivation.

In this connection, discussions were held at the request of HMA President, Dr. Tomita, regarding the expansion of the Maternity and Infant Care Project in Nanakuli and the establishment of similar projects in Palolo, Waimanalo, and Hilo. Also discussed was the government's definition of "high risk."

The legislative history of this program is based on the concept that there are large numbers of women in "high-risk," low-income families who are receiving poor or no prenatal care, who have a high incidence of complications of pregnancy, and who deliver prematurely two or three times as frequently as the average for the nation as a whole. Such infants are especially vulnerable to brain damage, neurologic disability, and mental retardation. The following are examples of conditions or circumstances which are considered to increase the "risks" of childbearing for mother and infant: Toxemias of Pregnancy; Dystocia, Hemorrhage; Concurrent medical conditions such as diabetes, anemia, malnutrition, hypertension and infections; RH incompatibility; multiple pregnancy; threatened premature labor; pregnancy in women under 16 and over 40 years of age; Out-of-wedlock pregnancy; Grandmultiparity; History of premature births, miscarriages, etc.; History of previous birth of infants with cerebral palsy, metabolic disorders, etc.

Finally, we are proud to announce that the infant mortality rate for 1966 in the State of Hawaii was 18.9 (per 1,000 live births), a figure which compares favorably with some of the best in the country.

RECOMMENDATIONS: (1) It was requested by the HMA President that a protocol be developed for handling correspondence to attending physicians whose cases are classified by this committee. It was decided that the minutes of the meeting and the committee's final classification can be sent to the attending physician, consultant, or hospital administrator and if there are any questions, those concerned are to be invited to call the chairman and write, or attend, the next scheduled meeting. Emphasis is always to be made that this is a committee geared primarily towards education and that all cases must be dis-

cussed anonymously with such details of hospital names, time, racial ancestry, etc., that would easily lead to identification left out of the protocol. Approval of this procedure is requested.

(2) A question was received from Dr. Leo Bernstein, Director of Health, regarding the use of obstetrical beds for clean surgical and gynecological cases. The committee voted approval of the HMA Hospital Committee's recommendation that there is no objection to the use of obstetrical beds for such cases provided that the control of the use of these beds be under the supervision of the Ob-Gyn Department of the Medical Staff, and that administrative decisions regarding beds be cleared with the Chief of the service. Approval of this action is requested.

(3) The committee feels there is need for a means of standardizing practices related to the treatment of erythroblastosis. It is felt that a committee on immunizations can be formed under the auspices of the Blood Bank of Hawaii. This committee to be made up of a representative of the Blood Bank, a pediatric hematologist, and two or three obstetricians. The function of the committee to be to offer free consultative services to local physicians concerning various disease involving blood immunizations and pregnancy, and to offer services for the performance of various diagnostic and therapeutic procedures. This committee will be asked to set up criteria for performing intrauterine transfusions. Approval of this proposal is requested.

(4) The committee feels that there is need for a thorough investigation of the Medical Examiner's system in this State and recommends that an ad hoc committee be appointed for this purpose.

BUDGET: The committee would like to see a budget reinstituted for use in holding meetings on the neighbor islands. If one meeting a year is held and four members are sent with a $20.00 per diem, cost would range from $210.00 to $245.00 depending upon which island the meeting is held. We thereforre request a budget of $250.00.

FRANCIS TERADA, M.D.

*Maternal and Perinatal Mortality Study Committee*

Your Reference Committee next considered the report of the Maternal and Perinatal Mortality Study Committee. Your Reference Committee commends this committee for its continued effort to reduce maternal and perinatal mortality within this State and notes the low infant mortality rate in 1966 as being evidence of the value of its work.

Your Reference Committee agrees with the concept of standard practice related to the treatment of erythroblastosis, however, it feels that the final control over the performance of these procedures is the prerogative of the individual hospitals. Therefore, your Reference Committee would recommend that Recommendation (3), line 12 be amended to read "This committee will be asked to *suggest* criteria. . . ."

After considerable discussion, your Reference Committee agrees that there may be reasons to question some policies within the Medical Examiner's System in this State. However, the committee feels that a review of the areas of concern may be more in order than a thorough investigation of the whole system. Therefore, your Reference Committee recommends that Recommendation (4) be amended to read: "The Committee feels that there is need for a *review* of the Medical Examiner's System. . . ."

Your Reference Committee recommends that this report, excluding the budget request, be accepted as amended.

Your Reference Committee feels that there is value in having members of the Maternal and Perinatal Mortality Study Committee present programs for the various county medical societies. However, your Reference Committee feels that this should be done only at the request of the county medical society and that they should be expected to bear expenses incurred. Therefore, your Reference Committee recommends that this budget request not be approved.

**ACTION:**

**The Chairman moved adoption of this portion of the report. It was adopted.**

## MENTAL HEALTH COMMITTEE

The Mental Health Committee accepts the definition of its functions as proposed by the Bylaws Committee.

The activities of this committee for this year have included:

(1) The development of classes and programs for non-psychiatric physicians in mental health was facilitated by the formation of a steering committee for the continuing education of physicians in mental health. The steering committee is composed of representatives of the Hawaii Academy of General Practice and the Hawaii Psychiatric Society as well as representation from members of this committee. The steering committee has already sponsored two eminently successful one-day seminars, one at the Kahala Hilton Hotel and the other at the Kauai Surf. In the future, formats of seminars will undoubtedly be varied, but it will very likely be that one-day seminars will continue to be part of the educational approach. In 1966, two seminars were held which consisted of ten two-hour sessions each. One was specifically directed towards pediatricians and the other was for general physicians.

(2) The committee discussed and approved three new mental health bills which at this juncture have been submitted to the Legislature by the Department of Health as "administration bills." These include: (A) *Interstate compact agreement:* This brings Hawaii in line with the majority of other states in order that agreements for the care and transportation of mentally ill residents of Hawaii and other compact states can be facilitated. (B) *Revision of the mental health laws:* This is a comprehensive act designed to streamline and modernize the various laws of the State of Hawaii pertaining to the mentally ill and includes a simplified involuntary hospitalization procedure. (C) *Revision of laws pertaining to criminal responsibility:* This law attempts to modify current legal concepts regarding criminal responsibility of the mentally ill. Drs. Audrey Mertz and George Schnack were members of the group who helped to formulate these proposals.

(3) The committee continued to discuss the possibility of a suicide prevention center but no action as yet has been taken. The general feeling is that further study is needed before such a center is set up. During the year, Dr. Edwin Schneidman of the NIMH and a leading expert in the field of suicide prevention centers, lectured to a group which included invitees of this committee.

(4) The committee continued its attempt to play a meaningful role in the development of insurance programs involving mental illness and its prevention. The committee supported the idea of a fee for service per unit of time for psychiatric work.

(5) The committee met with the chairman of the School Health Committee and supported that committee's idea that a physician should be included in the clinical diagnosis made by the Department of Education.

(6) Members of the committee continued to represent the Hawaii Medical Association in the Governor's Vocational Rehabilitation Plan, the Governor's Coordinating Committee for Implementation of the Comprehensive Mental Health Plan, and the Mental Health Association.

(7) Comprehensive Mental Health Centers are becoming a reality. The first on a private basis is developing at The Queen's Hospital. Since many of the members of this committee are also members of the psychiatric attending staff of that hospital, liaison with the development of the comprehensive mental health center in that hospital has been good.

RECOMMENDATIONS: A. Policy Decisions: (1) At this juncture, in fee negotiations with insurance carriers, it is recommended that whenever a HMA committee is in-

volved with a health plan, that a psychiatrist be included on that committee inasmuch as more and more programs are indemnifying psychiatric care. (2) It is recommended that the policy of appointing at least an equal number of nonpsychiatrist physicians to the Mental Health Committee be continued. (3) It is recommended that there be at least one joint meeting between the School Health Committee and the Mental Health Committee each year to discuss ways and means the HMA can implement better mental health programs and practices in the schools.

B. Future Activities: (1) In the event that the bills mentioned in this report are not passed, it is recommended that the committee continue to work for their passage during the coming years, and to help revise them as ideas and concepts change in the future. (2) It is recommended that continued support be given the steering committee for the continuing education programs for nonpsychiatric physicians in mental health. (3) It is recommended that the HMA continue to press representation on the various planning committees and community committees relating to mental health. (4) It is recommended that the HMA continue to seek NIMH support for the seminars or the training of nonpsychiatric physicians in mental health. (5) It is recommended that the HMA continue to investigate programs to interest and recruit capable young people into psychiatry and other mental health professions.

BUDGET REQUEST: (1) Every spring the AMA sponsors a conference on mental health in Chicago. This conference has always been of great interest to specialists and nonspecialists in the field of mental health since it is at this conference that the general tenor and direction the AMA is taking is expressed. We believe it is important that Hawaii be represented at this conference not only to discuss what progress we have made, but also to gather ideas and to see how other associations are solving their problems. To this end we are requesting that this committee send one delegate with his expenses paid and so we request $500.00.

KWONG YEN LUM, M.D.

*Mental Health Committee*

Your Reference Committee next considered the report of the Mental Health Committee. The Reference Committee reviewed the report of this committee and commends the committee on its activities. Your Reference Committee noted that mental health legislative measures supported by the Mental Health Committee were all passed with the exception of the measure relating to criminal responsibility. Your Reference Committee recommends that this legislation be pursued in future sessions of the Hawaii State Legislature.

Your Reference Committee concurs that specialty interests should be consulted in the matter of fee negotiation with insurance carriers but feels that it is unwise to mandate the inclusion of any one group on a fee negotiating committee. Therefore, your Reference Committee recommends that line 4 of Recommendation A. (1) be amended to read "that a psychiatrist be *consulted by* or included on that committee. . . ."

Your Reference Committee recommends that the Mental Health Committee report, excluding the budget request, be accepted as amended.

Your Reference Committee agrees that it is of value for Hawaii to be represented at the AMA Conference on Mental Health in Chicago but it does not feel that the Hawaii Medical Association should assume financial responsibility for those attending.

**ACTION:**

**The Chairman moved adoption of this portion of the report. It was adopted.**

## RADIATION COMMITTEE

The committee has met monthly and has been following the definition of the purpose and function of the committee: To work closely with doctors, hospitals, and government agencies in surveillance of radiation use; to assure the health and safety of patients and medical personnel.

Taking the notice that the use of ionizing radiation is a useful but dangerous mode of therapy, the committee has been working mainly on two problems.

First, the registration and inspection of all x-ray machines. The Department of Health has reasonable regulations concerning the registration and the use of x-ray machines which can be enforced. Under the direction of Mr. Iwashita, the supervisor of the occupational and radiological health section of the Department of Health, the Department of Health has inspected all dental machines. They are now involved in the inspection, registration, and checking of other x-ray units in hospitals, clinics, doctors' offices, and those in the offices of osteopaths and chiropractors. Because of the obvious problem of the chiropractors' "full length" films and the large exposure required to the patients, priority of checking will be given to the machines of the chiropractors. Mr. Iwashita is to give us a follow-up report on this in the next month or two.

The second problem involves the use of radium in hospitals. Letters were sent to all hospitals in Hawaii asking if radium is used and what standards for protection were followed. Each hospital received as well a copy of the standards approved by the HMA. To date, our response to this has been quite good. However, we are still to hear from several hospitals, but it appears that oud hospitals are following the basic standards.

Because the committee feels strongly about the use of ionizing radiation only by qualified individuals, work will be continued along these lines, and hopefully in the future, we will be able to advise those hospitals that request aid in setting up rules and regulations concerning the use of ionizing radiation in order to better protect the patients and medical personnel.

RECOMMENDATION: (1) That next year's committee continue to work towards promulgating regulations which will assure that ionizing radiation is used only by qualified individuals.

WILLIAM J. NATOLI, M.D.

*Radiation Committee*

Your Reference Committee next considered the report of the Radiation Committee, and commends the members for their continued surveillance of radiation use. Your Reference Committee recommends that this report be accepted.

**ACTION:**

**The Chairman moved adoption of this portion of the report. It was adopted.**

## SCHOOL HEALTH COMMITTEE

The committee held monthly meetings the first Friday of each month throughout the year. The members were in active attendance.

The committee acted as an advisory committee to the Department of Education and the Department of Health in all matters relating to school health. It also attempted to communicate with the private schools in this area.

During the past year, the following school health programs and policies were reviewed and discussed:

*Physician in Attendance at All Interscholastic Football Games.* In pursuit of the resolution passed by the Hawaii Medical Association's House of Delegates in 1966, the committee received responses from Governor Burns, Dr. Lowell Jackson, and Dr. Leo Bernstein that this would be implemented as soon as possible. The committee has felt that the next area of pursuit should be exploration of coverage for active intramural sports. Letters were sent to all schools to inqure about athletic health insurance and policies for care.

*Psychological Testing and Referrals.* A meeting was held with Dr. Paul Inouye and Mr. Izu of the Department of Education (Special Services) in regards to medical interpretation and recommendations made directly to the parents by psychologists and counsellors before the family physician is notified of the testing results. After much discussion it was felt that (1) there should be written consent forms signed by the parents before these tests are given, (2) the interpretation of psychological problems or disorders should be left to the family physician, and (3) that closer liaison should be established between the Department of Education Special Services and the School Health Committee.

*Unified Health Forms.* Considerable time was spent in regards to the pro and con of the unified health forms. Mrs. Winniger, health specialist from the Department of Education, spent some time with the committee discussing Forms 14 and 15 which are used in public schools. Since Public Health regulations specify that the Department of Health supply a form for entry to school, Form 14, the pupil's medical report, was felt acceptable to the committee at this time. Form 15 was corrected. The unified health form failed to gain total support of the committee and thus the committee felt that it could not completely support the form this coming year. Except in its limited function such as for summer camps and Boy Scouts.

*Guide for Medical Evaluation of Candidates for School Sports.* The committee reviewed the AMA's Guide for Medical Evaluation of Candidates for School Sports and a mimeographed form adopted by the Denver, Colorado, School Health group of the Academy of Pediatrics. Modifications were made and the final form circulated to the Departments of Education and Health and physicians. It is felt that this should be made available to all physicians dealing with students participating in sports.

*VD Manual.* The VD Committee reviewed a manual which they felt worthy of sending to the various schools. The School Health Committee reviewed this also and felt that it was worthwhile. The committee strongly recommended that this be made available to all schools. The problem of financing this manual at $2.00 a copy and distribution of the manual was not pursued.

*School Health Aides and School Physician.* Many lengthy sessions were devoted to this major problem. It was the unanimous decision of the committee that the ideal recommendation of this committee to the Department of Education and Health is to seek a top medical administrator and to include school health aides. A final recommendation of the School Physician was drafted and circulated to the Superintendent of Schools, Board of Education chairman, and Department of Health for consideration and approval.

The committee strongly urges continued pursuit of the creation of a school physician and school health aides. This is a major problem in improving the over-all development of school health programs. A full-time physician, knowledgeable in school health, can be the administrator of the various programs in the Department of Education. His outline of duties has been listed and is on file in the HMA offices. Following the creation of medical administrator, the school health aides can function with authority and knowledge. This could bring to focus much of the fragmentation that occurs from school to school in health education, first aid care, emergency service, physical fitness programs, and courses in healthy living.

RECOMMENDATIONS: (1) That there be follow-up to determine status of psychological testing. (2) That the prime objective of the School Health Committee in the ensuing year be pursuit of a program to implement the recommendation that there be a full-time physician administrator assigned to the Department of Education.

CALVIN C. J. SIA, M.D.

*School Health Committee*

Your Reference Committee next considered the report of the School Health Committee. Your Reference Committee noted the activities of this committee and its active interest in all aspects of school health and commends them for this.

Your Reference Committee recommends that, for the sake of clarity, the last line of Recommendation (2) be amended to read: "that there be a full-time physician administrator *in the Department of Health* assigned to the Department of Education." Your Reference Committee recommends acceptance of this report as amended.

**ACTION:**

**The Chairman moved adoption of this portion of the report. Dr. Quisenberry was asked to speak on recommendation No. 2. Dr. Quisenberry stated he had met with the School Health Committee and with representatives of the Department of Education. He also noted that the Governor, on several occasions, stated that he wanted the health people to be in the Department of Health, not in the Department of Education. He also felt that it would be more appropriate for such a division to be under the supervision of a physician rather than the Department of Education and nonphysicians.**

**The Reference Committee's report was adopted.**

## TUBERCULOSIS COMMITTEE

There were no formal meetings held during the year since there was no new business to be discussed; however, informal discussions were held with Dr. Marks.

It should be noted that the same difficulties pertain this year as last in the detection and treatment of tuberculosis in Hawaii; that is, there is no over-all supervision of the program. The treatment itself, either on an outpatient basis at Lanakila or Leahi or on an inpatient basis at Leahi, is quite satisfactory, but coordination among Lanakila Health Center, Leahi Hospital, and the practicing private physician is poor. I believe little further progress can be made in the irradication of tuberculosis or reduction of the tuberculosis problem in Hawaii unless a single person or office has over-all supervision of all the aspects of tuberculosis detection, control, and treatment.

The previous difficulties noted in the last report concerning somewhat prolonged hospitalization at Leahi Hospital have been largely corrected.

Communication between Leahi and the referring physician concerning patients under treatment or released from the hospital remains deplorable. Patients are leaving Leahi Hospital without referral back to their private physicians and without medical summaries being sent to the referring physician. Also, the referring doctor is not consulted in any aspect of his patient's care while in Leahi.

RECOMMENDATIONS: (1) Tuberculosis detection, treatment, and control should be under the supervision of one person. (2) Leahi Hospital should observe the usual professional amenities with patients referred for care.

JAMES J. BALL, M.D.

*Tuberculosis Committee*

Your Reference Committee next considered the report of the Tuberculosis Committee. Your Reference Committee feels that this report is a report of an individual and not a committee. Your Reference Committee therefore recommends that this report not be accepted. We further recommend that the Tuberculosis Committee for the coming year review the tuberculosis control program in this State and invite written comments from practicing physicians.

**ACTION:**

**The Chairman moved adoption of this portion of the report. It was adopted.**

## VENEREAL DISEASE COMMITTEE

This year the committee was once again separate from the Communicable Disease Committee in order to better investigate the venereal disease problem in Hawaii and implement the recommendations of the AMA on VD control.

Four meetings were held and the following were investigated or studied: (1) The incidence of VD in the State, (2) VD control measures, and (3) VD education in the schools.

The venereal disease problem in Hawaii may be summarized as follows: (1) Following the national trend, there has been a gradual increase in reported incidence which may be considered "moderate" and comparable to the West Coast states, rather than "epidemic" as in some Southern and Eastern states. The incidence of gonorrhea appears to be remaining steady (about 600 cases a year), whereas syphilis increased to 66 cases for the last fiscal year, a 74% increase over the previous year. This increase indicates the need for continued efforts for VD control and education, but as yet does not warrant the formation of a "joint statewide committee" as recommended by the last committee. (2) Educational efforts need to be continued in the following three areas in order of importance: (a) The schools (60% of all VD affects teenagers and young adults, the greatest increase being in the 14 to 19-year-old group. Concerted efforts need to be made in this area as the VD education program in most of our schools is inadequate). (b) The physicians (reporting of cases and the importance of epidemiologic interviews need continued emphasis. (c) The general public. (3) Because of the rising incidence of VD in minors, legislation permitting the examination and treatment of minors for VD without parental consent is needed for an effective VD control. Such legislation has been introduced this year by the HMA's Legislative Committee.

RECOMMENDATIONS: (1) There should be continued educational efforts directed to young adults through the school system, physicians, and the general public. In this area a closer working relationship with the Department of Health would increase effectiveness. (2) Strong and immediate efforts should be made, with the offered support of the PTA Congress, to get the *Student's Manual On Venereal Disease* ($1.00 each) in every intermediate and high school library and available in sufficient numbers for all school health classes beginning in the eighth grade by 1968. (3) Continued efforts to obtain legislation permitting examination and treatment of minors for VD without parental consent should be made if the bill now before the Legislature is not passed. (4) Assessment of the VD problem indicates that this committee would function as effectively, with unduplication of effort, by again being made a part of the Communicable Disease and Immunization Committee, as suggested by the Chairman of the Commission. (5) That the formation of a Statewide VD Committee as proposed by last year's committee not be carried out unless an indicated need is evidenced.

ROBERT KIM, M.D.

*Venereal Disease Committee*

Your Reference Committee next considered the report of the Venereal Disease Committee. Your Reference Committee commends this committee for its work. Testimony from the floor would indicate that there is considerable work to be done by this committee but that it could possibly be handled as a part of the Communicable Disease and Immunization Committee as recommended in this report. Your Reference Committee therefore recommends the adoption of this report.

**ACTION:**

**The Chairman moved adoption of this portion of the report. It was adopted.**

## WATER SAFETY COMMITTEE

The committee met two times during the year. The committee concentrated mostly on cardiopulmonary resuscitation. The committee felt that the Hawaii Heart Association should be used quite extensively since they have all the necessary material; i.e., films, etc., to keep the committee up to date on resuscitation matters.

The committee invited Mr. William Smith, of the Parks & Recreation Department of the City and County, and Mr. Oren Myers of the Red Cross, as resource people.

RECOMMENDATIONS: (1) That the committee concern itself only with medical matters in regard to water safety. (2) That a neurosurgeon be added to the committee to help advise in the management of neck injuries.

ELMARS M. BITTE, M.D.

*Water Safety Committee*

Your Reference Committee next considered the report of the Water Safety Committee. Your Reference Committee recognizes the need for continued effort in this area and recommends acceptance of this report.

**ACTION:**

**The Chairman moved adoption of this portion of the report. It was adopted.**

## RESOLUTION NO. 2

Re: Misuse of Drugs

WHEREAS, The misuse of the many drugs such as the amphetamines, barbiturates, and tranquilizers, and the misuse of the so-called "harmful substances" such as glue and other similar aromatic products, remains a continuing problem; and

WHEREAS, Juvenile drug arrests have increased tremendously in the past several years; now, therefore be it

*Resolved,* That the dangers of misusing and the advantages of correctly using drugs should be taught to all children; and be it further

*Resolved,* That such education should be a continuing important part of the total curriculum of Health Education; and be it further

*Resolved,* That this should be started no later then the beginning of the intermediate school age.

Submitted by SCHOOL HEALTH COMMITTEE

*Resolution No. 2*

**ACTION:**

**The Chairman moved that the resolution be adopted. It was adopted.**

## RESOLUTION NO. 3

Re: Need for Continued Venereal Disease Education

WHEREAS, The over-all incidence of venereal disease is decreasing but especially in the 15 to 24-year-age group continues to remain at a high level; and

WHEREAS, Continuing educational efforts have proved to be effective when vigorously and continuously applied; now, therefore be it

*Resolved,* That all physicians, public health personnel, and other agencies involved in health education continue their efforts toward venereal disease eradication; and be it further

*Resolved,* That schools, particularly, continue to pursue a vigorous program of venereal disease education as part of communicable disease instruction in the health education curriculum; and be it further

*Resolved,* That this should be started no later than the beginning of the intermediate school age.

Submitted by SCHOOL HEALTH COMMITTEE

*Resolution No. 3*

**ACTION:**

**The Chairman moved that the resolution be adopted. It was adopted.**

**RESOLUTION NO. 4**

Re: Local Implementation of Federal Legislation

WHEREAS, Education legislation with health components is currently being implemented at the local level; and

WHEREAS, The implementation of such legislation requires the participation of physicians, dentists, nurses, and allied health personnel; and

WHEREAS, Those expected to execute the health components of such legislation should share in planning its execution; now, therefore be it

*Resolved,* That local agencies preparing guidelines for education legislation involve the medical, dental, nursing, and allied health professions in planning implementation of programs; and therefore be it further

*Resolved,* That State and local medical societies contact the appropriate educational authorities or other responsible agencies with respect to implementation involving health components.

Submitted by SCHOOL HEALTH COMMITTEE

*Resolution No. 4*

**ACTION:**

**The Chairman moved that the resolution be adopted. It was adopted.**

**RESOLUTION NO. 5**

Re: Balanced Curriculum

WHEREAS, It is essential to teach health effectively in all our schools; and

WHEREAS, Each year demands are made upon the schools to emphasize certain more dramatic issues in the health curriculum; and

WHEREAS, We encourage updating and improving the health curriculum; now, therefore be it

*Resolved,* That schools be encouraged to be flexible enough to meet the current needs of our times; and be it further

*Resolved,* That schools make every effort to teach all important aspects of health with the proper emphasis and to discourage an overemphasis on popular problems at the expense of a total balanced health education program for children and youth.

Submitted by SCHOOL HEALTH COMMITTEE

*Resolution No. 5*

**ACTION:**

**The Chairman moved that the resolution be adopted. It was adopted.**

**RESOLUTION NO. 6**

Re: Consumer Education

WHEREAS, The American people spend an estimated billion dollars a year on unneeded health and sometimes harmful health and health-related products; and

WHEREAS, Many of today's consumers are unable to discriminate among qualified health personnel, irregular practitioners, and members of the healing cults; and

WHEREAS, Unqualified health cultists and unethical advertisers resort to misinterpretations, misconceptions, and misrepresentations to sell their services and their products; and

WHEREAS, These practices of purchasing unneeded health products, of being unable to discriminate among health personnel, and of believing unethical advertising result in the delay of or in the lack of needed medical care; and

WHEREAS, Carefully organized and properly integrated consumer education, within the health curriculum, could prepare future generations to evaluate critically claims made for health products and health services; now, therefor be it

*Resolved,* That the schools in every community incorporate appropriate units on consumer education into their health education programs; and be it further

*Resolved,* That competency in critical analysis of advertising and ability to discriminate between qualified and unqualified health personnel be the goal of such instruction; and be it further

*Resolved,* That the American Medical Association and the Food and Drug Administration be requested to continue to sponsor periodic conferences on quackery and health; and be it further

*Resolved,* That the resource units currently being developed under the sponsorship of the American Medical Association on consumer education and health be widely distributed and utilized in the schools of Hawaii.

Submitted by SCHOOL HEALTH COMMITTEE

*Resolution No. 6*

**ACTION:**

**The Chairman moved that the resolution be adopted. It was adopted.**

**RESOLUTION NO. 7**

Re: Professional Preparation of All Teachers and Administrators

WHEREAS, It is recognized that some teacher education institutions are to be commended for including the study of health problems, health practices, and methods of teaching health in the curriculum required for all teachers and administrators; and

WHEREAS, Numerous teacher education institutions offer such a course of study only on an elective basis; and

WHEREAS, All elementary and secondary teachers and administrators share the responsibility with parents and their medical advisors for the health education of students; now, therefore be it

*Resolved,* That it be a requirement that all prospective teachers and administrators participate in professional courses of health education to qualify for recommendation for certification; and be it further

*Resolved,* That in-service training program be offered in the various school districts to supplement and upgrade the education of teachers and administrators currently in the profession.

Submitted by SCHOOL HEALTH COMMITTEE

*Resolution No. 7*

**ACTION:**

**The Chairman moved that the resolution be adopted. It was adopted.**

**RESOLUTION NO. 18**

Re: Incidence of Venereal Disease

WHEREAS, Recognizing that the true incidence of venereal disease in Hawaii makes infectious gonorrhea and syphilis the most prevalent of communicable diseases in the State; and

WHEREAS, Two-thirds of the cases occur in our teenage and young adult population (under 30 years of age); and

WHEREAS, Neither disease is necessarily harmless or easily cured; and

WHEREAS, We consider this situation one of major importance; and

WHEREAS, With the State population approaching three-quarters of a million people with an estimated annual visitor rate of more than one million people; and

WHEREAS, If ignored, this problem will become worse; and

WHEREAS, We believe that in recent years the Department of Health has underfunded its VD "control" program (less than $6,000 annually) and has not initiated an effective statewide VD eradication program; now, therefore be it

*Resolved,* that the Hawaii Medical Association recommend that a positive, forward-looking, statewide VD eradication program based on the principles in *The Eradication of Syphilis: A Task Force Report to the Surgeon General, Dept. of HEW, 1962* and in *The Proceedings of the World Forum on Syphilis, Dept. of HEW, 1962,* which also apply to gonorrhea, be put into effect with the Department of Health, the private physicians, and the community hospitals working together for the general good of our community; and be it further

*Resolved,* That an intensive effort be inaugurated to enlist the private physician and his professional societies and associations in the control effort; and be it further

*Resolved,* That a program be established to insure that all laboratories processing blood for syphilis report all positive specimens by name of patient; and be it further

*Resolved,* That current interview-investigation services be intensified and extended; and be it further

*Resolved,* That a comprehensive and dynamic education program be developed for professional workers as well as for the public; and be it further

*Resolved,* That research in the immunology of syphilis, the therapy, and in laboratory procedures be continued and that research in adolescent and young adult sex behavior should be greatly expanded; and be it further

*Resolved,* That as the reported infectious syphilis morbidity curve begins to drop (as it surely will when the full impact of the all-out effort described in this resolution starts to take effect), the Federal, state and local governments continue unstinted their support of the program.

Submitted by RICHARD W. M. DANG, M.D.

Co-sponsored by SAMUEL D. ALLISON, CORA LEE AU, FRANCIS T. C. AU, MARIO P. BAUTISTA, DONALD CHAR, EDWIN K. CHUNG-HOON, EDWIN R. CURPHEY, EDWARD T. EMURA, GEORGE GOTO, ANDREW C. IVY, JR., HAROLD M. JOHNSON, ROY M. KAYE, MASURU KOIKE, JOHN A. KRIEGER, WILFRED H. KURASHIGE, FELIX J. LAFFERTY, THOMAS K. L. LAU, ROWLIN L. LICHTER, DONALD C. MARSHALL, ROBERT K. MOOKINI, JR., ANDREW L. MORGAN, DANIEL D. PALMER, DONALD A. PECK, CALVIN C. H. SIA, FRANCIS H. SOON, PAUL TAMURA, RAYMOND M. TAMURA, FRANCIS M. TERADA, BENJAMIN C. K. TOM, RAYMOND M. WILLIAMS, CAROLINA D. WONG, LAWRENCE Y. W. WONG, BERNARD J. B. YIM

*Resolution No. 18*

Your Reference Committee recommends the following revisions: In the seventh WHEREAS, that the last portion of the paragraph starting with the parenthesis and ending with the semi-colon be deleted so that the paragraph will read: "WHEREAS, We believe that in recent years the Department of Health has underfunded its VD "control" program; now, therefore be it. . . ."

The third resolved to read "That a program be established to insure that all laboratories processing blood for syphilis report *to the Department of Health* all positive specimens by name of patient. . . ."

**ACTION:**

**The Chairman moved that this resolution be adopted with the recommended revisions.**

**There was considerable discussion about whether or not gonorrhea should be included in the third resolved. There was also considerable discussion about whether or not laboratories are mandated by law to report positive specimens.**

**Dr. Quisenberry was asked to comment on the law. He stated that under the law all physicians must report all communicable diseases. Dr. Quisenberry did not think the law required laboratories to report positive specimens.**

**It was voted to grant Dr. Richard Dang the privilege of the floor to explain the legal aspects to the delegates.**

**Dr. Dang stated that the law as it reads states that all private physicians are required to report and it also requires laboratories to report. Under laboratories it states that any person who is in charge of a laboratory in which a laboratory examination for any specimen derived from human or animal bodies viewed microscopically, bacteriologically, immunologically, serologically, or by any other method shall promptly report its findings to the Department of Health.**

**It was voted to amend the Reference Committee's recommendation so that the third Resolved would read "That a program be established to insure that all laboratories processing blood for syphilis and culture for gonorrhea report to the Department of Health all positive specimens by name of patient. . . ."**

**The resolution was adopted as amended.**

Mr. President, your Reference Committee Chairman wishes to thank the members of the committee for their genuine support in the writing of this report.

Mr. President, I move the adoption of this report as a whole, as amended.

## REPORT OF REFERENCE COMMITTEE ON PARLIAMENTARY AFFAIRS

Mr. President and Members of the House of Delegates:

Your Reference Committee met before an audience of approximately ten physicians and guests and received testimony on the various resolutions and reports submitted to the Committee for consideration and recommendation. Having heard the discussion of the witnesses and having given careful consideration to all the testimony presented to it, your Reference Committee is pleased to make the following report:

### ARRANGEMENTS COMMITTEE

The committee met the usual number of times in its work of making plans for this year's annual meeting. Many of the traditions will be unchanged, but there are innovations planned which we hope the members agree will make the meeting more interesting.

*Golf:* There is still a problem in scheduling this tournament. This year it will take place on Friday and to date 67 have indicated they will participate. Advance registration indicates that holding the tourney on a week day is being well received. It has been suggested by the golf chairman that the tournament be rotated among Waialae, MidPac, and Oahu Country Clubs. He also recommended that the chairman be a member of the club where the tourney and connected social functions are scheduled, and that arrangements be made one year in advance. It was suggested that instead of trophies, there be cash prizes.

*Picnic (Sportsmen's Night):* Because of declining attendance in recent years, this event was eliminated and replaced by "Sportsmen's Night." It is hoped that all the doctors will attend, whether or not they participate in the tourneys. Awards for all three sports events will be made at this evening affair, which will be an informal dinner on Friday night at the Waialae Country Club. Eighty-eight members have indicated ahead of time they will attend this function. The scheduling was made pos-

sible when the Scientific Program Committee decided that inasmuch as Friday night scientific sessions have been poorly attended, there would be no program scheduled for this night. Traditionally the awards have been made and the Presidential Address given on Friday night. These will take place at the banquet on Saturday, along with the installation of the newly elected officers and the remarks of the newly installed president.

*Fishing:* The fishing tournament will take place on the Sunday prior to the annual meeting. Charter boats have been engaged and 24 are expected to participate. The Fishing Chairman recommended that negotiations be started in January in order that more advantageous financial arrangements can be made for next year.

*Tennis:* The tennis tournament will also take place on the Sunday prior to the annual meeting.

*Exhibitors:* The space for exhibitors is more limited this year due to the simultaneous use of four separate meeting areas.

*Headquarters Hotel:* The committee attempted to negotiate with the Ilikai Hotel for this year's meeting, but this hotel's regulations and charges made the selection seem unwise. Meeting space is becoming more and more limited and relief from this shortage is not in sight prior to 1969. It is hoped that when Hilton adds more meeting rooms to its Hawaiian Village complex, the situation will improve.

*Banquet:* A very special event is planned to culminate this year's annual meeting. Dr. Thomas Chang is in charge of the entertainment and an all-out effort is being made to make this an outstanding evening. Mrs. Raymond Yap and Mrs. H. Q. Pang are in charge of the seating arrangements. The $10.00 ticket will have two drink chits attached and also include one bottle on each table. A seven-course Chinese dinner will be served. Usherettes will help the guests find their tables. These girls will have their dinner served elsewhere but will be invited back to the ballroom to enjoy the program with their partners. Mrs. Maurice Silver was appointed by the Woman's Auxiliary to help with the decorations. HMA members are being urged to invite guests and make up their own tables. However, singles will be accommodated. A head table will be set up for the master of ceremonies and others who will speak during the evening. Their wives will also be at the head table.

*Registration:* Mr. Patrick Godfrey has been put in charge of the registration. In view of the registration fees being waived, he has worked out a different arrangement for passing out badges and tickets. No badges will be passed out the night of the Fireside chats, but a registration table will be set up for the convenience of the doctors who attend this event. The Woman's Auxiliary has again been asked to assist.

*Aloha Committee:* The responsibility for meeting and transporting guests was assumed by the Scientific Program Committee.

RECOMMENDATIONS: (1) That next year's committee begin meeting early in the summer in order to be certain that proper accommodations can be arranged. (2) That in the future the golf tourney be scheduled on a rotational basis at different courses. (3) That for the next annual meeting serious consideration be given to holding the sports events on the same days of the week as this year. (4) That the HMA continue to solicit prizes. (5) That if Sportsmen's Night is the success it appears it will be, that this event replace the picnic for next year's annual meeting. (6) That registration fees for HMA members be waived for the next annual meeting.

HERBERT Y. H. CHINN, M.D.

*Arrangements Committee*

Your Reference Committee first considered the report of the Arrangements Committee. No one appeared to discuss this report.

Your Reference Committee feels that the Arrangements Committee has done an excellent job in planning the 1967 meeting. Your Reference Committee recommends that the suggestion of cash prizes instead of trophies for the golf tournament be left to the discretion of the Golf Committee. The recommendations 1—6 as outlined in the report were reviewed and your Reference Committee unanimously recommends acceptance of these recommendations.

**ACTION:**

**The Chairman moved adoption of this portion of the report. It was adopted.**

## AWARDS COMMITTEE

The committee had one meeting to consider candidates for the Robins Award.

No suggestions were forthcoming for the Lane Bryant Award.

In November the committee submitted the name of Dr. R. Frederick Shepard to the President's Commmittee for the Employment of the Handicapped as a nominee for the annual physician's award. Dr. Shepard was awarded a certificate of appreciation for meritorious services, which was presented to him by Governor Burns. Subsequently, the House passed a resolution (HR 156) commending Dr. Shepard.

JOHN J. LOWREY, M.D.

*Awards Committee*

No one appeared to discuss this report.

Your Reference Committee considered the report of the Awards Committee and recommends that this report be accepted.

**ACTION:**

**The Chairman moved adoption of this portion of the report. It was adopted.**

## BYLAWS AND PARLIAMENTARY COMMITTEE

The committee met on March 9, 1967. The following topics were discussed:

1. Bureau of Planning & Research: This Bureau is a newly appointed committee and is being written into the Bylaws. The function of the Bureau is to develop and initiate long-range plans and programs. There was discussion about the number of members to be appointed and the length of time each member should serve. The Bureau suggested staggered terms to have continuity. It was voted that members of the Bureau shall serve for three years, one-third to be appointed each year.

2. Medical Disciplinary Actions: A reprint from *JAMA* listing medical disciplinary action was studied. It recommended that a mechanism be set up whereby all such action would be reported by the counties to each state medical association. It was voted to take no notice of the recommendation.

3. Physicians transferring from one place to another: This matter was discussed and it was noted that there is no uniformity among the counties in this regard. No conclusion was reached.

FRANCIS T. C. AU, M.D.

*Bylaws and Parliamentary Committee*

No one appeared to discuss this report.

Your Reference Committee noted that no specific Bylaw changes were outlined in the report and recommends that before the next session of the House of Delegates the Bylaws and Parliamentary Committee submit a detailed report giving the exact wording of proposed changes in line with the recommendations proposed by the House of Delegates at both the 110th and 111th Annual Meetings of the Hawaii Medical Association.

Your Reference Committee recommends that this report be accepted.

**ACTION:**

**The Chairman moved adoption of this portion of the report. It was adopted.**

## LEGISLATIVE COMMITTEE

The definition of committee function should be: The committee shall represent the Association in securing legislation which is in the best interest of public health and the advancement on standards of medical practice and conversely to oppose legislation which would be detrimental to the best interest of public health and the advancement in standards of medical practice. All legislative matters studied by other committees of the Association shall be coordinated through this committee.

The committee met for the first time on July 15, 1966, and subsequently at intervals of two to four weeks until the beginning of the general session of the 4th State Legislature, at which time the committee met weekly. The committee has considered the recommendations and suggestions of the House of Delegates and the various committees of the Association. The following is a brief summary of some of the significant activities of the committee:

1. The committee worked closely with the State Commission on Children and Youth in developing a Child Abuse Bill which was acceptable to the Association. We were able to obtain the support on our requests of all agencies which will become involved in the child abuse area once the bill is passed. We testified at all the hearings in the Legislature regarding this bill and the final version which passed final reading on April 26 is acceptable to the Association.

2. The committee opposed the provision of H.B. No. 833 which would have allowed equal compensation of optometrists and ophthalmologists on insurance cases for visual care and services. Largely through the efforts of our counsel, we were able to have this provision eliminated from the bill in its final form.

3. The committee testified in favor of the "Good Samaritan Law" but did not actively push for the enactment of this bill because the law will not protect the physician from legal action for rendering aid at an emergency any more than at the present time. The prime purpose of the bill is to create a favorable psychological effect on the medical profession and the public and to prevent civil suits for assault and battery.

4. The Washington State Disciplinary Law was reviewed with the idea of adopting a similar law for Hawaii. After holding several meetings with our legislative counsel and with the Director of State Department of Health, the committee is of the opinion that there are sufficient legal means within the Medical Practice Act for disciplining erring members of the medical profession in this State and that no further laws are necessary in this area at the present time.

5. The committee supported H.B. No. 215 which was enacted and which would lead to greater control of drug abuse by making conviction for the illegal use of LSD and other harmful drugs a felony.

6. The committee opposed the bill which would mandate prescriptions of drugs by the use of generic terms. The committee was opposed to the bill primarily because the physician would have no control on the quality of drugs that the patients may receive if the pharmacist is allowed to use his discretion in choosing the brand name of the medication for the patient.

7. Revision of the Workmen's Compensation Law to allow for a uniform fee schedule for the State rather than separate schedules for each county was supported. It passed final reading and was signed into law.

8. The ordinance in Los Angeles County which makes illegal congregation of spectators at the scene of disaster was obtained. The ordinance allows for restraint of spectators so that rescue operations can be carried out in the case of fires and other disasters. The police already have this power in the various counties so no action was taken in this area.

9. The committee met with the Legislative Committee of the Hawaii Cancer Society regarding the possibility of having enacted a law to prevent cancer quackery. Following a lengthy discussion with the Director of the State Department of Health, the committee is of the opinion that there are sufficient legal means to prevent cancer quackery at this time. We would like to urge the members of the Association to report any suspicion of cancer quackery to the State Department of Health so that the present law can be enforced in this area.

10. The committee has had introduced a bill relating to the granting to minors who are or who profess to be either married, pregnant, or afflicted with a venereal disease the power and legal capacity to give effective and valid legal consent to the provision of medical or surgical care or services. This bill passed final reading on April 27.

11. The committee supported several bills which would update the mental health laws in the State.

Our legislative counsel, Mr. Edwin Honda, will comment on other significant medical bills which were introduced during the session.

RECOMMENDATIONS: (1) That in regard to the liberalization of the abortion law in Hawaii (H.B. No. 76) the committee adopted the following statement by a vote of eight to four as the position of the Hawaii Medical Association until such time as the House of Delegates adopts, rejects, or modifies this position: Therapeutic abortion may be performed in a licensed hospital accredited by the Joint Commission on Accreditation of Hospitals by a duly licensed physician with proper consultation for those patients who seek it when: (a) there is substantial risk that continuance of the pregnancy would greatly impair the physical or mental health of the mother; (b) there is substantial risk that the child would be born with grave physical or mental defect; or (c) the pregnancy resulted from rape or incest. Approval for the abortion must be given in a licensed hospital accredited by the Joint Commission of Accreditation of Hospitals with proper consultation of at least three physicians. In case of rape or incest, information must be obtained from the prosecuting attorney to the attending physician that there is probably cause to believe that the alleged violation occurred, and such information is not to be evidence in any other proceeding.

(2) That the invaluable services of Mr. Edwin Honda be acknowledged and his contract be extended for another year to November, 1968.

BUDGET REQUEST:

| | |
|---|---|
| Clerical | $1,300.00 |
| Counsel | 6,000.00* |
| Dinner and Entertainment | 1,000.00 |
| Today's Health | 150.00 |
| Miscellaneous | 100.00 |
| TOTAL | $8,550.00 |

* This fee will include any expenses incurred by the counsel.

GEORGE GOTO, M.D.

*Legislative Committee*

Your Reference Committee had discussed the Legislative Committee report and heard testimony from Dr. George Goto, Dr. Keith Kuhlman, et al. It was felt that this was a very complex problem and after considerable deliberation on the various portions of Recommendation #1 regarding liberalization of the abortion law in Hawaii as set forth by H.B. No. 76, your Reference Committee recommends that this portion of the report be accepted in view of the fact that the hospitals and obstetrical societies would like to see that doctors' practices conform with modern medical knowledge and ethical standards. Your Reference Committee recommends that Recommendation #2 be accepted.

**ACTION:**

**A substitute motion was made and seconded that recommendation number 1 be disregarded and that the President of the HMA appoint an ad hoc committee, composed of two attorneys, two ob-gyn physicians, two general practitioners, and two clergymen (not Roman Catholics), to conduct an extensive study of this problem and to report back to the House of Delegates at the next meeting. The motion was lost by a vote of 19-18.**

**It was moved and seconded that this matter be postponed until the next House of Delegates meeting. The motion was lost when it failed to get a two-thirds vote.**

**It was voted to refer back to the previous question. The Reference Committee's report was adopted by a vote of 23-16.**

**The Chairman moved adoption of this portion of the report. It was adopted.**

## MEDICAL PRACTICE ACT COMMITTEE

The committee met once on February 10, 1967. At this meeting it was proposed that a change be made in the requirements for persons with National Boards in that they not be granted reciprocity with Hawaii after ten years from the date of their Part Three examination. This was reported to the Legislative Committee for action.

Further meetings of this committee were to be on call as necessary.

KEITH F. O. KUHLMAN, M.D.

*Medical Practice Act Committee*

No one appeared to discuss this report.

Your Reference Committee feels that this report should be accepted in view of the fact that the present trend throughout the various states is not to grant reciprocity after ten years from the date of the Part III portion of the National Boards.

**ACTION:**

**The Chairman moved adoption of this portion of the report. It was adopted.**

## NATIONAL LEGISLATION COMMITTEE

The committee developed the following definition of its functions: It shall gather information on all national legislation concerned with medical care, the practice of medicine, or public health. It shall discuss the pros and cons of legislation and regulations introduced for implementation by the Federal government and develop the official position of the Hawaii Medical Association on such matters. All position recommendations developed by the committee shall be approved by the Council before being transmitted to Congress.

The committee has followed the protocol set by the Council for transmitting the Association's position on national legislation; i.e., the position developed by the committee is transmitted by mail to the members of the Council, and if no objections are received, it is transmitted to Congress or the AMA over the President's signature.

By the end of July, 1966, the 89th Congress had introduced some 24,000 bills and 1,440 of these concerned medical care, the practice of medicine, or public health. The bills which were discussed in committee included: (1) Laboratory Animal Care, which became PL 89-544. (2) Traffic Safety (PL 89-563). (3) Military Medical Benefits (PL 89-614). (4) Comprehensive Health Planning & Public Health Service Amendments of 1966 (not enacted). (5) Mortgage Insurance for Group Practice Facilities (PL 89-754). Keogh Amendments (PL 89-751). (10) Commitment of Narcotic Addicts (PL 89-793). (11) Water Pollution Control Amendments (PL 89-753). (12) Medical Restraint of Trade Act (the Hart bill which was not enacted). (13) HR 18225, Title XIX, Amendments.

Unfortunately, the information on most of these proposed bills was received after the AMA representatives had made their stands known to Congress. However, in nearly all cases, the committee was in agreement with the stand taken by the AMA.

Bills on which the HMA's stand was formally transmitted to our members in Congress included the Laboratory Animal Care Act and the Medical Restraint of Trade Act.

Receiving serious consideration at present are HR 5710, the administration bill introduced to amend PL 89-97 (Medicare), and Senator Long's Generic Name bill (S-1303). Study of the following bills will be held in abeyance pending developments which might provide additional information: Pacific Medical Center, and transfer of activities relating to medical care from the House Interstate and Foreign Commerce Committee to the Committee on Education. The Hart bill appears to be losing support.

There are proposals in HR 5710 which merit the attention of the House of Delegates. The committee voted to oppose putting the under-65 disabled under Title XVIII, creating a Part C to cover hospital outpatient care and hospital-based physician payments, providing for Medicare benefits to be paid to Federal hospitals, inclusion of podiatry services as eligible benefits.

The committee voted to support the HR 5710 proposals which would repeal the three-day hospitalization requirement prior to admission to an extended care facility, state agency consultative services to laboratories, and free choice for medical assistance recipients.

Pending further information, no stand was taken on those sections covering depreciation allowance as part of allowable hospital costs, payment of limited licensed physicians, limitation on reduction of hospital services for certain illnesses, coordination of Title XIX and Part B of Medicare, modification of comparability requirements, payment of medical administrative costs, medical assistance advisory council.

In addition the committee voted to oppose the AMA's suggested amendment that would allow direct payment to Title XVIII patients without a receipted bill, and to support the AMA's amendment that would allow direct payment to Title XIX patients.

The committee is concerned over the proposed IRS regulation that would rule income from professional journals to be taxable as unrelated business income. This ruling could affect the HAWAII MEDICAL JOURNAL and would be of serious consequence to the AMA. It should be noted that the AMA derives considerably more income from its journal sales and advertising than it does from dues (in 1964 advertising accounted for 44.8%, journal subscriptions 9.9%, and membership dues 31.7% of the AMA's income).

RECOMMENDATIONS: (1) The committee should arrange to meet with the elected representatives and senators when they are in Honolulu. (2) The committee should make use of the elected Congressmen's local office to develop better means of communication. (3) Depending upon the status of the legislation being acted upon, the committee should transmit the Association's position to members of committees as well as to elected senators and representatives. (4) Because of the importance of this committee, only members who are willing to work, study the bills, and attend meetings should be appointed to it. Unfortunately, during the year the committee's work was hampered by very poor attendance.

L. Q. PANG, M.D.

*National Legislation Committee*

No one appeared to discuss this report.

Your Reference Committee tried to locate Dr. Lummis, who first expressed a desire to discuss this report. Your Reference Committee recommends that the recommendations one through four be accepted.

**ACTION:**

**The Chairman moved adoption of this portion of the report. It was adopted.**

## PENSION AND INVESTMENT COMMITTEE

This committee reevaluated and reviewed the following: (1) Investment policy. (2) HMA's current surplus funds account. (3) Employees' pension fund. (4) Physician's Benevolent Fund. (5) Long-range planning.

Three meetings were held and the following conclusions were reached:

With reference to the cash portion of the HMA's General Fund, the committee felt that because of the "fluid" nature of this fund, it would be a prudent policy to let these monies remain in the various short-term savings and loan accounts. They are presently earning a minimum of five per cent interest. Any other type of long-term investment for these monies would at the present time be unwise.

The committee agreed that the HMA Employees' Pension Fund should remain with the Hawaiian Trust Company, which acts as trustee, and that more continuing attention should be paid this Pension Plan to assure that it is tailored to employees' needs and the ability of the HMA to carry this financial program.

The Physicians' Benevolent Fund was the subject of considerable discussion. After thorough in depth consideration, the committee decided that this Fund's original concept of aid for the needy physician and his family be abandoned. The committee was unable to establish workable guidelines which would make the Fund operable on a practical and realistic basis. The Fund was begun in 1957 and, in the absence of any established policy, it is fortunate that no disbursements have been made. There has been only one request for aid. Previous committees were unable to establish clear-cut guidelines to make this inadequate fund operable. The problems encountered involved an insufficient corpus, voluntary annual assessments, income production, qualifications of recipients, administration of the Fund when disbursed, etc. These problems have prevented the Fund's realizing its objectives and are simply too great to justify the Fund's continuation. Therefore, the committee decided that the existing fund of $28,500, plus accruing interest earnings, be left alone pending further study for its use.

The other item which took a large portion of the committee's time was developing a long-range financial plan for the Association. After considerable discussion, the committee agreed that the present Revision and Investment Committee should be dissolved and in its place there should be established a strong, responsible, aggressive, standing executive finance committee to operate on a year-round basis which would report direct to the Council. This proposed finance committee should consist of a chairman and eight members who would be appointed for five-year terms in order to insure continuity of experience and talent in this heretofore neglected and very critical phase of finances in the various HMA activities. In order to accomplish this goal the committee is cognizant of the need for a change in that portion of the Bylaws which designates the Council as the Finance Committee. This proposed finance committee should have as one of its first projects the development of a five-year program that would include a comprehensive, detailed master plan. It should provide for the execution of the steps in this master plan until it is fully implemented. A goal of the committee should be the establishment of an official state medical association headquarters consisting of sufficient land and building space to accommodate the ever-expanding activities of the HMA. This would be the first step in the long-range financial master plan of the HMA to have the doctors themselves initiate and develop in the State of Hawaii their own home. This would serve as the beginning of a medical center in the Pacific, in our rapidly-expanding, jumbo-jet-age era. If we do not do the job now in our way, the politicians will do it for us—their style. The committee is mindful of its financial obligation to Mabel Smyth and does not feel this plan presents a conflict.

RECOMMENDATIONS: (1) That the cash reserves continue to be kept in savings and loan accounts for the present time. (2) That no change be made in the employees' pension plan but that the next committee give more attention to this program. (3) That the PBF original concept of aid for the needy doctor be abandoned. (4) That no Physicians' Benevolent Fund assessment notices be sent out in 1967. (5) That ultimately the Physicians' Benevolent Fund be dispersed. (6) That the Pension and Investment Committee be eliminated from the HMA's roster of standing committees. (7) That this serve as legal notice that the House of Delegates when next in session will vote on the following proposed change in the Bylaws: Chapter V, Section 3 (a) now reads "The Council shall serve as the executive body of the Association between sessions of the House of Delegates, as the Board of Censors of the Association, and as the Finance Committee, and shall carry out such other functions as may be delegated to it by the House of Delegates. (f) As the Finance Committee it shall order an annual audit of the accounts of the Treasurer and other agents of the Association and present a statement of the same, together with a budget for the coming year, in its annual report made by the Treasurer to the House of Delegates. All monies received by the Council and its agents, resulting from the discharge of duties assigned to them, must be paid to the Treasurer." These two sections to be changed to read: (a) The Council shall serve as the executive body of the Association between sessions of the House of Delegates, as the Board of Censors of the Association, and shall carry out such other functions as may be delegated to it by the House of Delegates. (g) The Council shall appoint a Finance Committee which will be directly responsible to it. The Finance Committee shall advise the Council on all fiscal matters. (f) The first three words, "As the Finance Committee" should be deleted and "it" capitalized. (8) Until a new Finance Committee can legally be constituted, the work of this committee should be carried out under a committee entitled "Financial Advisory Committee to the Council." (9) That the new committee develop an appropriate definition of its duties to be included in the Bylaws. (10) That the membership of the new committee be restricted to eight members plus a chairman. (11) That since the new committee will be responsible direct to the Council, the President should submit the names of his nominees to the Council for approval. (12) That appointments to the new committee be for a period of five years, but that initial appointments be made for staggered terms of from one to five years, and that its members be chosen for their special talents in the field of finance and investment—particularly in real estate development experience. (13) That the new committee develop a five-year master plan for submission to the House of Delegates at its next meeting. (14) That the new committee in its master plan include recommendations relative to developing adequate HMA-owned headquarters to accommodate the future activities of the ever-expanding state Medical Association. (15) That the new committee consult with the Bureau of Planning and Research relative to future HMA activities.

RAYMOND C. YAP, M.D.

*Pension and Investment Committee*

No one appeared to discuss this report.

Your Reference Committee discussed this report and recommends acceptance of recommendations 1 - 15 as stated.

**ACTION:**

**The Chairman moved adoption of this portion of the report. It was adopted.**

## SCIENTIFIC PROGRAM COMMITTEE

With great sadness and heavy heart, I took over the work of the late Bob Ho to try to tie together the remaining loose ends still not resolved at the time of his sudden death on January 13. The selection of speakers and initial arrangements were completed and few changes were made.

The scientific sessions will again be held at the Princess Kaiulani Hotel. The first session, however, will be in the Diamond Head Wing. In view of the poor Friday night attendance, this session was eliminated and in order to be able to present a better rounded program, sessions have been scheduled for Wednesday morning and evening. Dr. Frederick Giles graciously agreed to move his Fireside Chats to Tuesday evening in order to permit us to do this.

A new format is being experimented with which provides for two sessions of round table discussions to take place in four different areas. In order to do this, the exhibit area had to be reduced.

Grateful acknowledgment is made to the following organizations who contributed amounts varying from $50.00 to $4,000.00 (Eaton) and who made this year's program possible: Eaton Laboratories, National Foundation—March of Dimes, E. R. Squibb & Sons, Hoffman-La Roche, Inc., Schering Corp., The Wm. S. Merrell Co., Wallace Laboratories, Strasenburgh Laboratories.

Committee members have been appointed to act as an Aloha Committee to meet the various speakers and to see that they have transportation to and from the various events. Each of the six sessions will have one of the committee members acting as the moderator. Each round-table discussion area will also have a committee member assigned to oversee the arrangements for that section.

In addition to the seven mainland speakers, three of our own physicians will give papers. Drs. Stanley Wright, Ian Shine, Richard Blaisdell, and James Chung of the University will participate, and Dr. Phyllis Wright of the Birth Defect Center will present clinical cases.

For the first time, registration fees for HMA members will be waived. It is hoped that this will increase attendance and will not adversely affect the Association's budget.

RECOMMENDATIONS: (1) That next year's committee start no later than June to plan for the scientific program. (2) That consideration be given to holding a meeting on a neighbor island in 1969.

R. VARIAN SLOAN, M.D.

*Scientific Program Committee*

Dr. Varian Sloan came to discuss this report. Your Reference Committee would like to commend Dr. Sloan for doing an excellent job in continuing the preparations for the scientific program initiated by one of our colleagues, the late Dr. Robert P. C. Ho. Your Reference Committee recommends that the recommendations one and two be accepted and further recommends that for the purpose of continuity some of the members of the present committee be retained to plan the next scientific program.

**ACTION:**

**The Chairman moved adoption of this portion of the report. It was adopted.**

## COMMISSION ON EDUCATION & SCIENTIFIC RESEARCH

This being the first time that a commissioner system has been instituted in the Hawaii Medical Association, it was somewhat difficult to define the limits of responsibility of the commissioner and the role that he should assume in various committees which came under his aegis. Perhaps it may be profitable at this point to institute a general set of rules of operation within which the commisisoner will operate but which have enough flexibility whereby each commissioner will be able to exercise deviations as needed.

With regard to the various committees which were within my supervision, there were no significant deviations from the normal manner in which each committee operated. It is my feeling that each chairman should be allowed to express his views without much interference from the commissioner but should operate or be advised with regard to the views of committees involved in the same areas so that there is no duplication of effort and there is coordination of effort.

There has been some feeling that certain committees should be deleted. Since there has been little interest in these areas, this may be a good idea. However, if there are other committees which need to be formed these should also be considered.

RAYMOND M. TAMURA, M.D.

*Commission on Education and Scientific Research*

Dr. Raymond Tamura testified. Your Reference Committee recommends that specific guidelines be adopted for the commissioners and that the Committee on the Hawaii Academy of Science be deleted as its only function is to present an award each year, its function being delegated to the Awards Committee.

**ACTION:**

**The Chairman moved adoption of this portion of the report. It was adopted.**

## COMMISSION ON INTERNAL AFFAIRS

My tenure as chairman of this Commission was less than a full term. I replaced the late Robert P. C. Ho and do not feel that my experience has been sufficient to enable me to reach final conclusions. However, I should say that it seems logical to group under one head committees with similar activities. They then become, in effect, subcommittees, and are more easily integrated into the over-all role of the Association. I know this type of organization is in effect in other medical societies, and it would seem to be especially applicable here because all the HMA committees are required to report at each Council meeting. When these reports can be channeled through one of six Commissions, the deliberations of the Council should be less time consuming. It would seem logical, therefore, that the reports to the Council be made by the commissioners rather than by committee chairmen, and I would suggest that a change be made in the Bylaws to make this type of reporting possible.

COOLIDGE S. WAKAI, M.D.

*Commission on Internal Affairs*

The late Dr. Robert P. C. Ho was initially selected to chair this Commission on Internal Affairs. Your Reference Committee discussed this report and recommends that the commission system be retained and that appropriate changes be made in the bylaws to provide for incorporation of the commission system into the Association's organizational structure.

**ACTION:**

**The Chairman moved adoption of this portion of the report. It was adopted.**

## COMMISSION ON LEGISLATION

The Commission on Legislation did not hold any meeting as a Commission in view of the fact that the chairman of the Commission was also chairman of the Legislative Committee. Since the members of the Commission on Legislation were also members of the Legislative Committee, all pertinent business relating to legislation at the local level conducted in their respective committees was channeled through the Legislative Committee; therefore the need to hold separate meetings did not arise. In developing consensus opinions on certain controversial proposals for legislation, each member of the Commission conducted meetings of his own respective

committee prior to submitting his proposals for legislation to the Legislative Committee. In the Committee on National Legislation, however, only proposed national legislation which could have local ramifications was referred to the Legislative Committee for study and recommendations. The chairman of the Commission attended the meetings of the component committees of the Commission in order to intelligently channel pertinent information through the Legislative Committee. The report of each committee on the Commission and the report of our Counsel on Legislation are submitted as being part of this report.

Creating a favorable climate at the Legislature for certain legislation that is in the best interest of public health and the advancement in standards of medical practice is a long and arduous task. For this reason the chairman of this Commission requests members of this Association to exercise restraint in publicly expounding opinions that are contrary to the stated positions of the Association. If such opinions must be expressed, the prior airing of such opinions in the appropriate committees of the Association seems to be indicated. Without a spirit of cooperation of this type, the long hours spent by members of this Association in its various committees for the good of the Association would be largely negated and important pieces of legislation favorable to the Association may be killed.

GEORGE GOTO, M.D.

*Commission on Legislation*

No one appeared to discuss this report, however, after a short discussion, your Reference Committee is in full accord with this report and, therefore, recommends its acceptance.

**ACTION:**

**The Chairman moved adoption of this portion of the report. It was adopted.**

## COMMISSION ON MEDICAL SERVICES

This year the President grouped the committees of the Hawaii Medical Association under six super-committees or Commissions. This organization was established to facilitate the work of the committees and to assist the officers in their duties. The commissions are made up of the HMA officers, the four county presidents, and the chairmen of the committees involved.

The Commission on Medical Services found this a rather natural organization since under the previous Medical Care Plans and Fees Committee there were several subcommittees such as Fee Survey, Negotiation, etc. These committees were retained as separate committees under the Commission and other committees with related functions were added.

With the benefit of past experience, the Commission has generally worked smoothly and efficiently. Since the functions of several committees overlap and since these boundaries are changeable, the Commission structure proved valuable in differentiating these functions and assigning specific tasks to a specific committee or committtees.

Since we did not have specific guidelines to tell us how to function, this Commission developed its own method of operation. The principles by which it functions are as follows:

1. The Commission meets at least bimonthly.
2. Actions and recommendations are by vote after full discussion.
3. The Commission assigns specific responsibilities to committees as necessary.
4. Reports of meetings of its various committees are circulated to all members of the Commission.
5. The Annual Reports of each committee (except that this year in the case of the Medical Care Plans & Fees Committee there was not sufficient time to do this) are reviewed by the Commission prior to being sent to the printers.

Since we do not wish to make specific recommendations and since the functions and work of the other commissions may differ, we have listed the above guidelines with the thought that they may be helpful to other commissions.

RECOMMENDATIONS: That the House of Delegates approve the commission organization established by Dr. Tomita and that the House of Delegates continue to explore methods of improving the organization and work of the committees and commissions.

RICHARD D. MOORE, M.D.

*Commission on Medical Services*

No one appeared to discuss this report.

Your Reference Committee commends Dr. Tomita on his foresight in organizing the commission system to operate the Association in a more efficient and systematic fashion. Your Reference Committee, therefore, recommends acceptance of this report and recommendation.

**ACTION:**

**The Chairman moved adoption of this portion of the report. It was adopted.**

## COMMISSION ON PUBLIC HEALTH

Dear Dr. Tomita: I am leaving this week for a postgraduate study program at Harvard and will not be here for the annual meeting and all its preliminaries. I wish I could be here to ride herd on the completion of the annual reports but I cannot. I have sent another letter to each committee chairman prodding him in this effort.

I thought I would set down a few opinions of my own for you as a sort of annual report from myself. First of all, I have enjoyed working with you very much and I only regret that we did not have time to spend in more discussion. I think I did not understand my function clearly until midyear; then it took even longer to really get onto the multitudinous problems under consideration. As a result, I am not sure I was of any significant help to you. If anything, I did try to help each committee be aware of their interrelationship and tried to coordinate some of our efforts.

I have a few suggestions to make briefly. The first is that further consideration be given to making committee appointments for more than one year. The lack of some continuity in membership seriously handicaps some committees. I think the Maternal and Perinatal Mortality Committee is an excellent example of how things might be better structured where each member is appointed for three years and the terms are staggered. This committee incidentally was my first experience with the Hawaii Medical Association work when I was a resident and remains one of the most outstanding in my opinion. My second suggestion is that a few committees be recombined, specifically the Communicable Disease and Immunization Committee with the Venereal Disease Committee and the Tuberculosis Committee. I know there was a feeling last year that the VD control was a highly specialized effort, but I think this pressure was short-lived and I never saw that particular physician who so loudly proclaimed the need for a separate committee at any of its meeting this year. As a matter of fact, by isolating this committee from the over-all communicable disease work I think it suffered. The Tuberculosis Committee was totally inactive. I think a well-composed committee including persons knowledgeable in commnicable diseases and immunizations in general and physicians especially interested in venereal disease and tuberculosis would be of much greater service to our membership. The Mental Health Committee is a potential giant and I am afraid it does not receive the attention it deserves or the support it needs. A tremendous amount of Federal and State interaction with private medicine is occurring here as you know and we are, in most instances, generally unaware of the importance of this work. In my opinion, a very strong, widely representative committee is needed

here, one including not only psychiatrists but general practitioners pediatricians, internists, surgeons, and even consultants from some of our paramedical medical groups. Representative physicians from State and Federal agencies are also needed to provided insight into many of these problems. The work and deliberations need more attention from membership in general and this might be done for this committee and others by a quarterly report in the *HMA Newsletter*.

The challenge to the Hawaii Medical Association is staggering. So staggering that I am not at all confident that we can even presume to stay abreast of current problems and further developments. As you know I tried to explore the current sentiments as to our function in particular in relationship to state agencies who most often ignore help and suggestions. I would finally like to suggest that we reappraise our role in 1967-68 and if we feel burdened to continue the multitudinous advisory roles we are currently engaged in, then some consideration might be given to having a full-time physician executive director, someone who could devote full-time to birddogging some of these projects and who could advise and counsel the committees from the advantage point of a former practicing physician.

To be president of this organization must be a tremendous burden not only of work but of all responsibility and I know I could not measure up to it. You have done a marvelous job and it has been a pleasure to have been associated with you and the work. Again I regret only that we did not have enough time to interact and that I will not be here for the annual meeting.

RECOMMENDATIONS: (1) That HMA committee appointments be for more than one year. (2) That the Venereal Disease and Tuberculosis Committees be recombined into the Communicable Disease and Immunization Committee (3) That the Mental Health Committee be more widely representative of the various medical and paramedical specialties. (4) That a full-time physician executive director be employed.

JOHN R. STEPHENSON, M.D.

*Commission on Public Health*

Dr. John Stephenson was not available to discuss this report. Therefore, your Reference Committee, after a serious discussion, felt that recommendations Nos. 1, 2, and 3 should be accepted and that recommendation No. 4 should be deleted because having a full-time physician as an Executive Director would not be utilizing his talents to the utmost. Recommendation No. 2 should be accepted pending revisions of the Bylaws.

**ACTION:**

**The Chairman moved adoption of this portion of the report. It was adopted.**

## COMMISSION ON PUBLIC & INTERPROFESSIONAL RELATIONS

The creation of commissions has helped to coordinate the efforts of various committees of HMA. This organizational structure should be retained.

As commissioner of Public and Interprofessional Relations, I found it difficult at times to grasp the roles of various committees. There were instances in which one committee seemed dominant over others. This impression is probably due to my inexperience and another physician would have been more effective.

FRANCIS T. ODA, M.D.

*Commission on Public and Interprofessional Relations*

No one appeared to discuss this report.

Your Reference Committee recommends acceptance of this report.

**ACTION:**

**The Chairman moved adoption of this portion of the report. It was adopted.**

## BUREAU OF PLANNING AND RESEARCH

The Bureau has met several times this year, and early became involved in discussion of the need for a study of the adequacy of medical care in the community. It was early made cognizant of S 3008 (now PL 89-749) which would provide for Comprehensive Health Planning throughout the country. It met with officials of the Health Facilities Planning Council, and of the Heart, Cancer, Stroke Program.

The Bureau is of the belief that the Medical Association should take the lead in evaluating medical care in the community, and if Hawaii is not receiving all reasonable care, we should attempt to assure that such is provided. The Bureau developed a protocol for such a project and has requested aid from a number of nongovernmental agencies designed to bring about a feasibility study entitled "Determination of the Quality Medical Care in Hawaii." This protocol had approval of the HMA Council. As yet, other than one grant of $100.00 from the Watumull Foundation, no funds have been received to carry on the project.

In addition to this major activity, we have reviewed and made suggestions to the President concerning a study on pyloric stenosis, the need for a Committee on Emergency Medical Services, and a communication from the National Advisory Commission on Health Manpower.

Function: The Bureau is responsible directly to the Council and is to carry on whatever work it feels necessary to keep abreast of the times and prepare the Association to meet future challenges.

RECOMMENDATIONS: (1) It is recommended that this Bureau be continued and that it be made up of members appointed by the President with staggered terms of duty. This matter has been referred to the Bylaws & Parliamentary Committee for implementation.

SAMUEL D. ALLISON, M.D.

*Bureau of Planning and Research*

No one appeared to discuss this report.

Your Reference Committee reviewed this report and recommends acceptance of the recommendation.

**ACTION:**

**The Chairman moved adoption of this portion of the report. It was adopted.**

## RESOLUTION NO. 12

Re: Automatic Data Processing

WHEREAS, Automatic data processing is entering more and more into the practice of medicine, especially into its economic aspects; and

WHEREAS, The individual physicians, especially those not located close to large medical centers, will be increasingly in need of these services; and

WHEREAS, The Hawaii Medical Association is the logical nongovernment agency to assist the physicians of this State; now, therefore be it

*Resolved,* That an appropriate committee of the Hawaii Medical Association study the broad field of automatic data processing (including data processing of claims) to the end that the needs of physicians will be properly recognized in the programming of this rapidly developing facet of medical economics; and be it further

*Resolved,* That the committee appointed to this task make periodic reports to the members at no less than four-month intervals.

Submitted by J. MARK B. SOWERS, M.D.

*Resolution No. 12*

Your Reference Committee next considered Resolution No. 12 about which Dr. Mark Sowers testified. Mr. Tom Thorson also expressed his opinion regarding the BME future plans regarding data processing.

Your Reference Committee recommends that Resolu-

tion No. 12 not be adopted because we feel that this is an individual physician's matter.

**ACTION:**

**The Chairman moved that the resolution not be adopted. It was not adopted.**

## PRESIDENT'S REPORT

The work of the HMA becomes more complicated with every new change that evolves. Government is responsible for many of the changes. The physician of today is no longer able to divorce himself from the socio-economics of medical practice. He is required to employ additional clerical personnel to help take care of his "paper" work and soon, we are told, he will have to employ more paramedical personnel to perform duties which today he is doing himself. Every effort must be made by the HMA to try to keep the individual doctors informed of the changes that are evolving and to help them in every way possible. The busier the physicians become, the greater the effort has to be on the part of the HMA to see that they receive the help they need. It is not enough merely to make the information available to them, ways must be devised to see that the information is absorbed and put to use.

Inasmuch as availability of information is not enough, I should like to see the Association launch a program of individual education. In the past the effectiveness of eyeball-to-eyeball instruction for office personnel has worked well for the HMSA. A similar plan for the HMA which would encompass all phases of the nonmedical side of the doctor's practice would be covered. We doctors need a continuing education program.

One of the more frustrating developments during my term of office was the problem that developed with the plantations when Medicare went into effect. Although this started with the plantations, it will spread unless something is accomplished to prevent corporations, whether profit or nonprofit, from practicing medicine. A bill was introduced in this past session of the Legislature. However, like most new legislation, it was not passed. More work needs to be done in this area and we will continue to require legal consultation. Final resolution may require that this be settled in a court of law. It should be pointed out that the legislation that was introduced would in no way prevent the incorporation of physicians for the purpose of reporting income when, and if, the Internal Revenue Service permits this. The bill was opposed by the plantations.

Another important piece of legislation which was introduced, but did not have a hearing, would have, if enacted, permitted physician-sponsored organizations such as the Foundation to co-insure health insurance programs. This enabling legislation is necessary to lend stability and to guarantee that the physicians will make such programs successful. Until such legislation is passed, the doctors will not be able to work direct with such plans as the one that covers the Federal Civil Service employees.

The past year has been a busy one. As President I have made some half dozen trips to the mainland and went twice that number to the neighbor island societies. The day when the Association president made a social call once a year on the county societies is past. It was indeed an honor to have been elected to the highest office in organized medicine in Hawaii. It is also a responsibility. While President, I attended over 200 HMA meetings as well as countless other civic and government affairs and conferences. All that I have done will be worthwhile only if the individual members have benefited. I believe they have.

I would like to take this opportunity to express my appreciation to all the members who have given so much of their time during the past year to help carry out the aims of the Association. In an effort to streamline the organizations, all but two committees (the Bureau of Research and Planning and the Nominating Committees) were divided into six Commissions. The six Commissioners have been asked to report on their experiences in this newly created role. In general, I believe the system has worked well but, as with all innovations, there is room for improvement. The Commission system, among other things, was designed to keep the officers and the county presidents up to date on the activities of the 48 committees assigned to the Commissions. By being voting members of the Commission, these physicians are available to help with the interim guidance of the HMA's work. This should provide for more concenus and leave fewer areas of dispute for the House of Delegates to settle. It would be well for the Bureau of Research and Planning to look into the over-all structure and devclop recommendations.

In order to carry out the many functions of the Association, I firmly believe the era of austerity must come to an end. Physicians are just beginning to realize what is in store for them. They need organized medicine to keep them on top of new developments. In order to keep abreast of what is developing, I should like to see two research departments added to the Association structure; one in the area of government and the other in socio-economics. The government research department would be charged with developing and maintaining charts which would show activities of the city, county, state, and federal agencies. It would relate itself to the Legislative and Public Relations fields and provide information that is needed in testimony presented at public hearings and at conferences with other organizations. The socio-economic research department would develop statistics and make projections that would be used by many of the standing committees, as well as by the officers and others who must represent the Association in an advisory capacity to government agencies.

Again, I want to thank all the physicians whose help has made it possible to carry out my duties as President.

RECOMMENDATIONS: (1) That the Bylaws be changed to establish a "Finance Committee" but that during the interim, there be an "Advisory Finance Committee" which will meet at least once each month. (2) That the Bureau of Research and Planning look into the over-all committee organizational structure. (3) That the HMA obtain the personnel to establish two research bureaus: (a) one for government activities and the other (b) for socio-economic research. (4) That the House of Delegate provide for the employment of at least one individual who will routinely call on the individual doctors in their offices and confer with their staffs. (5) That the work to prevent corporations from practicing medicine be continued until a satisfactory result is obtained. (6) That an enabling act, which would permit expanded physician-sponsored health insurance programs be introduced in each session of the Legislature until it is passed. (7) That the proposed "advisory Finance Committee" explore the possibility of the HMA's forming subsidiaries which could engage in certain related business transactions for profit in order to partially subsidize the Association; i.e., real estate, data processing, computer services, etc.

THEODORE T. TOMITA, M.D.

*President's Report*

Your Reference Committee discussed the President's Report about which your President, Dr. Theodore Tomita, testified. Seven recommendations were made and your Reference Committee recommends the acceptance of all these recommendations.

**ACTION:**

**The Chairman moved adoption of this portion of the report. It was adopted.**

**It was voted that the Reference Committee's report be aeeepted and that reeommendation No. 4 be referred to the Counеil for implementation if it is eeonomieally feasible.**

**The Chairman moved adoption of this portion of the report. It was adopted.**

## SECRETARY'S REPORT

The total active membership of the Association as of December 31, 1966, was 743, an increase of 25 over December 31, 1965. In 1965 the increase was 41, in 1964 it was 17, in 1963 it was 37, and in 1962, 28. The inactive members, reported only through Honolulu County, numbered 13, an increase of two over the previous year. Of the 743 active members, 57 were granted dues waiver, an increase of two over the previous calendar year.

The total number of unlimited licenses issued to physicians to practice medicine in Hawaii as of December 31, 1966, was 1,293, an increase of 112. In preceding years this increase amounted to: 53 in 1965, 34 in 1964, 62 in 1963, and 75 in 1962. There were 400 physicians licensed to practice in Hawaii who did not reside in the State.

The first temporary and limited licenses was issued July 2, 1965. These licenses are valid for 18 months only except that interns and residents renew annually. Between July 2, 1965, and December 31, 1966, 230 such licenses were issued, 120 of them in the calendar year 1966. The breakdown of the T&L licenses issued in 1966 is as follows:

| | |
|---|---|
| Under the Direction of | 40 |
| Resident | 36 |
| Shortage | 3 |
| Government | 12 |

All counties except Honolulu grant active membership to physicians holding a temporary and limited license.

The number of military physicians in the State was obtained for the first time in 1965. This figure was not secured for 1966.

By counties, the active membership is made up as follows as of December 31, 1966:

| | ACTIVE DUES PAYING | ACTIVE DUES WAIVED | TOTAL |
|---|---|---|---|
| Hawaii | 52 | 6 | 58 |
| Honolulu | 588 | 47 | 635 |
| Maui | 34 | 2 | 36 |
| Kauai | 12 | 2 | 14 |
| TOTAL | 686 | 57 | 743 |

Eight members died during 1966: Merton Mack, Glenn Yanagi, Edward Shimokawa, L. L. Sexton, Paul Withington, George Straub, Frank H. Hatelid, and Robert W. Davis.

None of the counties has completed its reports. Honolulu county reported nonaffiliated members. The list submitted contained 152 names. No unlicensed nor temporary and limited licensed physicians were included in this list. Early in February, at the Council's request, a list of over 200 names supplied by the AMA was submitted for review. No reply to this letter was received. The Public Relations Committee prepared a list of names of nonaffilated physicians in the State and this list included over 300 names. Had a complete list of interns and residents been included, the list might have grown to about 400 physicians. On December 31, 1965, Honolulu County advised as follows: We do not have available to us the listings of Temporary and Limited licenses for Honolulu County. The Honolulu County Society does not recognize such licensure as qualifying for membership in the Society. We are unable to furnish the listing to Temporary and Limited licensees." Not having been advised to the contrary, it is assumed that there has been no change in the Honolulu policy.

Two problems have developed regarding membership classifications. The first involves members who transfer from another state medical association to which they have paid dues. The second involves the granting of inactive membership status to physicians who hold an unlimited license to practice medicine in the State of Hawaii. These matters should be clarified.

Since the last annual meeting there have been three Council meetings. These were held on August 31, February 1, and April 21. At the first of these meetings the Council voted to approve the Pharmacy Committee's request to endorse the policy that physicians instruct the pharmacists to "Label As Such" rather than "Take As Directed" and where the instructions are involved, say "use as per written on instructions." The HVB was advised that the HMA would approve the mailing of a brochure to its mebers and urge their support but that it is the policy of the HMA to contribute through individual members. The liability policy carried by the HMA was endorsed to include protection against slander and libel and the four county societies were given the opportunity to participate. Approval was given to reimburse Mr. Lytle for funds expended in attending the AMA's PR meeting. Mr. Ajifu's monthly fee was increased, the per diem for physicians traveling on the mainland was increased up to $50.00 a day, and members sent to the mainland by the HMA were given permission to travel on first-class tickets. A DSS fee schedule using the 1965 Hawaii RVS converted at 5.00 with a 30% subsidy in medicine and a 20% subsidy in surgery was approved for the period ending June 30, 1967. In view of problems arising in the hospital outpatient departments, the Council voted to reaffirm 1966 resolutions passed by the House of Delegates re Hospital Practice of Medicine and Free Choice of Physician and to send notice of these affirmations to all hospital administrators and chiefs of staff. Also reaffirmed at this meeting was the AMA report of the Judicial Council re contract practice. Each county society was urged to review all contracts with plantations existing in their counties and take appropriate action. It was voted to work with the HSPA and the unions towards securing free choice of physician and the concept of fee for service for plantation personnel. The following resolution was passed by the Council:

WHEREAS, It was illegal for corporations to practice medicine according to the Hawaii State Law; and

WHEREAS, Such practice is detrimental to the best interests of scientific medicine and of the people themselves according to the AMA Judicial Council; and

WHEREAS, The greatest incentive to scientific improvement will be destroyed and the public will be poorly served; now therefore be it

*Resolved*, That the Hawaii Medical Association go on record in support of free choice of physician for plantation pensioners covered under Medicare.

The Council voted to reaffirm the Negotiating Committee's request that physicians servicing Department of Health clinics be paid on a fee-for-service basis, using the section of medicine entitled "consultations" when applicable. Honolulu County was advised that Kuakini Hospital pathologists and radiologists had not conformed to the HMA resolution re Hospital Based Physicians. Letters on this subject were sent to neighbor island Boards of trustees. It voted to approve an appropriation for a dinner meeting with lay representatives connected with workmen's compensation coverage. It was also voted to institute legal action if the Workmen's Compensation fee schedule was not adjusted to reflect the going rates. Neither of these actions was implemented. After a review of the HMSA situation, the Council voted to commend the President in reappointing the Negotiating Committee and acked him in maintaining the same members. No change in the VA contract was though necessary. Increases in the salary structure of the four HMA staff members were approved.

At the February 1 Council meeting membership in SAMA was approved. A $1.50 cost for the RVS to government agencies employing HMA members was set. Information was sought to determine if the counties had any program for encouraging medical society membership for nonaffiliated physicians. Only Kauai answered. Council members' per diem was increased up to $30. It was voted that the cost of lunches served at committee meetings be paid for by the HMA, not to exceed $1.25 each. Dr. Tomita was reimbursed for the expenses he incurred in attending the AMA Las Vegas meeting. The audited figures for the 1965-67 fiscal year were published in the JOURNAL. The Chair ruled that the Nominating Committee report stand. Approval was given the Bureau of Research and Planning to seek outside funds for ob-

taining the services of an authority trained in analyzing the medical care of communities. The Medical Education Committee's proposed policy on payment of professional services for full-time University of Hawaii professors was returned for further study. The Chairman of the Medical Education Committee was sent to Chicago to attend the AMA Congress on Medical Education. Policies were developed on which lay and non-HMA physicians would have their annual meeting registration fees waived. The Hawaii Heart Association's minimum standards for cardiovascular clinics were approved, as was the Straub Research Foundation drug project. It was voted to recommend to the Department of Education that there be an Administrative Medical Department within that Department. The disaster protocol agreement for the State of Hawaii was approved. The salary of the moderator for the TV program was increased and an appropriation was made to purchase video tapes for use in connection with this activity. The President was commended for his graciousness in donating a view box for use on the TV programs. Funds were voted to send Mr. Rice to an AMA-ABA Medio-Legal meeting in Miami. However, he subsequently advised that after checking the subject matter of the meeting, his attendance would not further the HMA's purposes and so he did not attend. The following HAMPAC Board members were approved: Robert M. Miyamoto, William E. Iaconetti, Don E. Poulson (subsequently elected chairman), Rodman B. Miller, L. Q. Pang (subsequently elected vice-chairman), Herbert Y. H. Chinn, P. H. Liljestrand, George Goto, B. A. Richardson (subsequently elected secretary-treasurer), Yonemichi Miyashiro, Mrs. Robert Jay, Mrs. Eldon Dykes.

At the April 21 meeting the Council voted to give the AMA Delegate the responsibility to use his best judgment in voting on the matter of the AMA Disability Program. Attention was called to a problem in Medicare billing where it was proposed that consultants to plantation physicians bill the plantation physician rather than the patient. It was voted to suggest to Aetna that physicians who are not properly informed (sic) be referred to their component society and that the county societies be informed that Aetna will be referring these names to them for some course of action. The Council voted to donate a trophy for the BME to award to the Junior Medical Assistant of the Year. The Council went on record not to support the Hawaii State Health Council financially at this time and to write and ask that they fully explain their activities and how the activities will not be in conflict or reduplication of present laws (sic). A reply is requested in time for this matter to come before the House of Delegates. It was voted to appropriate money to cover the cost of developing an informational bulletin to be prepared by Mr. Rice on the necessity of HMA members' supervising their billing practices. The Council voted to send out a step-by-step bulletin outlining activities that have taken place which relate to HMSA. Various membership dues status were voted upon. May 22-25 was selected for the dates of the next annual meeting. The 1967-68 proposed budget was approved as was the recommendation that the 1968 dues be set at $140.00. Waiver of Annual Meeting registration fees for military physicians and non-MD professional people in academic work was approved. Funds were appropriated to bring out an authority to help the Bureau of Planning and Research secure the money it needs for developing a plan to evaluate medical care in Hawaii. The revised policy statement relative to medical practice by full-time faculty members was approved. It was voted to obtain permission to circulate Honolulu County's bulletins on plantation medicine and HMSA to the neighbor island members. It was pointed out that physicians should bill the DSS their usual and customary fees. Oral reports were given by Drs. Richard T. Mamiya and B. A. Richardson on the AMA meetings they had attended.

RECOMMENDATIONS: (1) That the House of Delegates set the date and place for the next annual meeting as follows: May 22-25 in Honolulu. (2) That the Council be granted permission to change the site and dates of the 1967 annual meeting if unforeseen events should develop to make a change advisable. (3) That the resolution adopted by the Council relative to corporate practice of medicine be approved. (4) That the AMA Delegate be instructed to use his best judgment in the way he votes on the matter of the AMA Disability Program. (5) That the House of Delegates review the letter requested from the Hawaii State Health Council and set a policy to govern the relationship the HMA should have with this organization.

R. VARIAN SLOAN, M.D.

*Secretary's Report*

Your Reference Committee discussed the Secretary's Report during which time two physicians testified. Your Reference Committee accepts recommendations Nos. 1, 2, 3, and 4 with the correction in date in Recommendation No. 2 from 1967 to 1968 and that Recommendation No. 5 be deleted because no reply has been received from the Hawaii State Health Council.

**ACTION:**

**The Chairman moved adoption of this portion of the report. It was adopted.**

## TREASURER'S REPORT

The breakdown of income and expense at the end of this report contains three columns: (1) Proposed budget for 1967-68. (2) Estimated actual expenses for 1966-67. (3) The amounts budgeted for 1967-68.

*1966-67 Income:* This will probably be about $6,000 more than anticipated due principally to increased revenues from dues, miscellaneous income, the probability of the Roster's showing a profit, and unanticipated reimbursement of expenses from the arrangement with CMA to help with compiling and distributing *What Goes On.*

*1966-67 Expense:* This will probably exceed budgeted amounts by approximately $12,500 due principally to the Council's action in increasing (1) the per diem for AMA meetings and authorizing first-class fare for the doctors attending these meetings. (2) Legal expenses incurred in connection with the Workmen's Compensation Hearings and contract medicine. (3) Paying for committee members' lunches. (4) Increased insurance coverage. (5) Removal of executive offices to a larger area. (6) Increases in salaries for the four staff members. (7) Authorized mainland travel not anticipated when budget was approved.

*1967-68 Income:* There will probably be less income during the coming fiscal year due in general to the slow down in membership increases, a smaller Roster, less interest income in view of the deficit incurred in the present fiscal year.

*1967-68 Expense:* The anticipated expenses will increase for the next year for the same reasons that they will be larger than anticipated for the current year. In addition, there will probably have to be an audit of the pension plan and taxes will go up. The amount of taxes paid is determined by the salaries paid plus the increased Social Security and unemployment rates. Committee expenses are only estimates. The exact amount will depend upon House action in approving individual committee requests.

*Comparative Figures:* The 1966-67 Budget as proposed would have shown an excess of income over expenses of $1,337.50. Actually, there will be a $5,000 deficit. The 1967-68 projected figures based on current rate of expenditures indicate a $17,270.00 in expenditures over income, a sum which is too large to be met through deficit spending.

*HFPC:* The following letter dated April 25, was received after the last Council meeting:

The Health Facilities Planning Council is seeking contributions to continue its planning activities into 1968 and 1969. The trustees wish to express their appreciation for your earlier contribution supporting our 1967 planning endeavors.

The budget for the 1968-1969 period is $112,000 which will be funded by a Public Health Service Grant of $56,000 provided that 50% of matching funds can be raised locally. To obtain the matching money, we are soliciting business and industry, insurance

companies, labor, trusts and foundations, Chamber of Commerce, hospitals, medical societies, interested civic groups and individuals. Since we are a nonprofit corporation, all contributions are tax exempt.

Hawaii is in the midst of participation in a vigorously growing complex field of health and medical care. Presently, there are plans for modernization and expansion of hospitals in Hawaii involving over $65 million during the next ten years. In one way or another business, labor and the public pays the major cost of building and maintaining hospitals and other patient care institutions through taxes, contributions, health insurance premiums and hospital rates.

The Council's basic purpose is through a voluntary planning effort to work with and assist all hospitals in planning and coordinating their future programs. The physician is a vital member of ths hospital planning process along with members of the hospital board and the administrative staff. You can be assured that such coordinated planning will not jeopardize the role of the physician and the Hawaii Medical Association in the hospital or the community. On the contrary, the Medical Association and the physician can become a source of considerable guidance as well as leadership.

RECOMMENDATIONS: (1) That the following budget for 1967-68, which has been recommended by the Council, be approved. (2) That the dues for the calendar year 1968 be set at $140.00. (3) That inasmuch as the Council didn't have an apportunity to review the HFPC request, the House of Delegates make the decision relative to further financial support.

HERBERT Y. H. CHINN

INCOME

| NAME OF ACCOUNT | PROPOSED BUDGET 1967-68 | ACTUAL EXPENSE ESTIMATE 1966-67 | ACTUAL BUDGETED 1966-67 |
|---|---|---|---|
| Membership Dues | $75,380.00* | $75,000.00 | $73,470.00 |
| Journal | (2,710.00) | (2,230.00) | (2,410.00) |
| Annual Meeting | 1,040.00 | 2,720.00 | 3,140.00 |
| Annual Roster | 50.00 | 1,150.00 | (2,000.00) |
| Interest Income | 3,000.00 | 3,500.00 | 3,000.00 |
| Miscellaneous Income | 1,700.00 | 1,700.00 | 900.00 |
| Miscellaneous Scientific Meetings | | | 200.00 |
| Gain or Loss on Various Activities | | | |
| What Goes On | 1,000.00 | 600.00 | |
| TOTAL INCOME | $79,460.00* | $82,440.00 | $76,300.00 |

EXPENSES

| | | | |
|---|---|---|---|
| AMA Convention | $ 5,510.00 | $ 4,000.00 | $ 3,200.00 |
| Audit, Accounting & Legal | 5,400.00 | 6,700.00 | 2,300.00 |
| Auto Expense | 1,200.00 | 1,100.00 | 600.00 |
| Council Expenses | | | |
| Travel | 840.00 | 300.00 | 780.00 |
| Meals | 400.00 | 360.00 | 240.00 |
| Per Diem | 780.00 | 220.00 | 400.00 |
| Donations | 20.00 | 20.00 | 20.00 |
| Meeting Expenses | 3,000.00 | 1,660.00 | 600.00 |
| Insurance | 850.00 | 800.00 | 500.00 |
| Library Contribution | 100.00 | 100.00 | 100.00 |
| Miscellaneous | 300.00 | 300.00 | 200.00 |
| Postage | | | |
| Stamps | 1,200.00 | 1,200.00 | 1,200.00 |
| Bulk Mailing | 700.00 | 700.00 | 400.00 |
| Permit | 30.00 | 30.00 | 30.00 |
| President's Contingency Fund | 500.00 | 130.00 | 500.00 |
| Rent | 4,490.00 | 4,300.00 | 3,170.00 |
| Repairs & Maintenance | 230.00 | 200.00 | 200.00 |
| Retirement | 4,200.00 | 2,660.00 | 2,630.00 |
| Salaries | 36,780.00 | 35,240.00 | 32,250.00 |
| Stationery, Printing & Supplies | 1,400.00 | 1,400.00 | 1,400.00 |
| Subscription & Dues | 870.00 | 880.00 | 880.00 |
| Special Authorized Expenses | 1,800.00 | 2,060.00 | 350.00 |
| Taxes | | | 1,400.00 |
| Social Security Taxes | 1,650.00 | 1,330.00 | |
| Unemployment Compensation | 1,700.00 | 1,600.00 | |
| All other taxes | 100.00 | 100.00 | |
| Telephone & Cable | 1,700.00 | 1,600.00 | 1,400.00 |
| Travel | 600.00 | 600.00 | 300.00 |
| Woman's Auxiliary | 3,430.00 | 3,400.00 | 3,330.00 |
| Furniture & Fixtures | 600.00 | 800.00 | 900.00 |
| Committee Expenses | 25,350.00* | 20,650.00 | 22,662.50 |
| | 105,730.00* | 94,440.00 | 81,942.50 |
| Less Journal Reimbursement | (7,000.00) | (7,000.00) | (7,000.00) |
| TOTAL EXPENSES | $98,730.00 | $87,440.00 | $74,942.50 |
| EXCESS OF | (19,270.00)* | (5,000.00) | 1,357.50 |

* Subsequently changed by House action as follows:

| | |
|---|---|
| Membership Dues | $95,900.00 |
| Total Income | 99,980.00 |
| Committee Expenses | 25,574.00 |
| Total Expenses | 98,954.00 |
| EXCESS OF INCOME OVER EXPENSE | $ 1,026.00 |

*Treasurer's Report*

Your Reference Committee discussed the report of the Treasurer. The budget was reviewed and your Reference Committee recommends the acceptance of the recommendations one and two noting that the difference in dues for the calendar year 1968 will be a $30 increase over 1967 for a total of $140. With reference to recommendation No. 3, your Reference Committee recommends that the Hawaii Medical Association give financial support to the Health Facilities Planning Council in an amount to be determined by the HMA Council at its next meeting.

**ACTION:**

**The Chairman moved adoption of this portion of the report. It was adopted.**

## LEGAL COUNSEL

There were miscellaneous general administrative questions reviewed with the officers and staff including publication of perinatal committee reports, and the better definition of unrelated income. Some assistance was given with reference to proposed legislation. The application of State statutes to the osteopaths, and hospital medical staffs were reviewed for one of the county societies who sought state Association advice.

Two major projects were dealt with during the year—the first, the Workmen's Compensation Medical Fee Schedule, involved preparation of four public hearings, three on the neighbor islands which were attended by counsel and the Association president.

The other major area of attention by our office during the past year has been that relating to contract practice of medicine, and the legal and ethical questions raised by proposed disbursements of Medicare receipts by doctors employed under contract. Extensive research has been undertaken on the illegality of corporate practice of medicine and allied questions. This matter is considered pending by our office.

Your attorney attended a conference of state medical society attorneys in April which provided valuable background information.

Your attorney has no recommendations.

V. THOMAS RICE, J.D.

*Legal Counsel Report*

No one appeared to testify.

Your Reference Committee discussed this report and recommends its acceptance.

**ACTION:**

**The Chairman moved adoption of this portion of the report. It was adopted.**

## LEGISLATIVE COUNSEL

The general session of 1967 started somewhat shakily as far as the upper house was concerned but by the 62d day, which was the final day, much legislation had passed both houses and had gone to, or was on its way, to the Governor for his signature. The number of bills passed amounted to 324, of which the House passed 215 and the Senate 109.

Several bills of interest to the Medical Association for some period of time passed both houses during this session among which were several bills relating to mental health, a child abuse bill, the uniform fee schedule in Workmen's Compensation cases. The Child Abuse Bill was enacted with the support of several community groups including the State Commission on Children and Youth. The bill was introduced as an administrative measure through the auspices of the Department of Social Services. The Hawaii Medical Association of course, lent its full weight of support toward enactment of this bill.

Another bill of significance, namely that which provides for a uniform fee schedule in Workmen's Compen-

sation cases throughout the State, passed both houses and was signed by the Governor quite early in the session. The legislators and the State Department of Labor and Industrial Relations were cooperative and helpful in the enactment of this law.

There were several bills relating to the donation of dead bodies and related bills, of interest to the University of Hawaii for medical purposes, which passed both Houses of the Legislature towards the end of the session.

A bill wherein optometrists sought to obtain equal fees with opthalmologists was modified and passed. The modification being that reference to equal compensation was deleted wherever it appeared in the bill. The bill as modified did not appear to be any real threat to the Hawaii Medical Association in any significant way.

The Legislature also passed a bill which allows a minor to give a valid consent to a doctor or hospital to be examined where such minor suspects pregnancy or affliction of venereal disease. The bill, as it passed both Houses, however, provided that after examination and finding the minor to be pregnant or afflicted with venereal disease, the parent of such minor must be notified by the physician or by the hospital which caused the examination. Considerable opposition developed in the final hours to the passage of this bill but considerable effort was mobilized to save the bill from defeat and with the understanding and assistance of certain legislators, the bill was passed on final reading.

There were several bills of significance to the Association which did not meet with success. Among said bills was the Good Samaritan Bill, the bill preventing corporations from practicing medicine, and enabling legislation for the Foundation for Medical Care, as well as the attempt at the liberalization of Hawaii's abortion law. The bills relating to practice of corporate medicine, the Good Samaritan bill, and the modification of the abortion law did see the light of hearings but did not succeed in coming out of committees to which said bills were assigned. It would appear that of these four bills, the one relating to abortion will be the stickiest, at least for the next few years. The fact, however, that Colorado and other states have enacted or appear to be giving serious consideration to such bills, may expedite the day that some change will be made in Hawaii's abortion law. It might be well to note here also that the Hawaii Medical Association will have to take a firm and clear stand relative to its attempt at liberalizing the abortion law.

Inasmuch as the Legislature was just concluded, the report submitted here is somewhat meager and requires more thorough analysis. Frankly speaking, this session might be considered a rather unusual one in that when the session convened, it appeared that it would be a relatively uneventful one in terms of legislation passed. This was further fortified by the difficulty that the Senate had in organizing during the first eight or nine days. However, as the days passed, it became more and more evident that much legislation would be enacted and the result shows a number of bills, some of far reaching consequence, were enacted.

My working relationship with Dr. Goto, Chairman of the Legislative Committee, and Dr. Tomita, President of HMA, was indeed mutually satisfying from my appraisal of the situation. I would like to thank these gentlemen as well as the organization for the opportunity to serve you.

EDWIN H. HONDA, LL.B.

*Legislative Counsel's Report*

No one appeared to discuss this report.

The Legislative Counsel report was reviewed and your Reference Committee would like to commend Mr. Honda for his excellent work and recommends acceptance of his report.

**ACTION:**

**The Chairman moved adoption of this portion of the report. It was adopted.**

## AMA DELEGATE'S REPORT

The last two meetings of the AMA's House of Delegates were held in Chicago (June) and Las Vegas (November). The next two meetings will be held in Atlantic City (June) and Dallas (November).

Before the AMA began publishing the "AMA News," the Delegate's report appeared in the HAWAII MEDICAL JOURNAL. However, since complete resumés are now available to the members through the AMA's releases long before they could be printed in the local JOURNAL, the expense of duplicating this information has been eliminated.

Your Delegate has been invited to the HMA Council meetings and is available for reporting at any time the members so request. Hawaii's remoteness from Chicago prevents our having day-to-day contact with the AMA headquarters, but information in copious quantities is sent out by the AMA. Fortunately, the California Medical Association has "adopted" the Hawaii delegation and for the past several years both Dr. Mills and myself have been invited to their caucuses, including their daily breakfasts. These invitations have been of invaluable assistance in learning more background information on the resolutions that are introduced. AMA policy is developed through resolutions more often than through the reports of the Board of Trustees and the committees. Most of the reports are developed at the request of the House of Delegates. The AMA Board of Trustees must operate within the policies set forth by the House. Occasionally, the House thinks the Board has acted contrary to the policies set and this results in a sharp reprimand.

Many states develop resolutions for introduction at the House of Delegates and this is the basis for the policy-making formula. Hawaii has not done this in the past and and I would urge that more thought be given towards playing a part in the policy-making processes of the AMA. Sometimes the policies are set by a very thin majority, other times the vote is overwhelmingly in favor or against a resolution. Seldom are the decisions unanimous.

In recent years there has been more activity on the floor of the House of Delegates despite long reference committee hearings. Most of the debate on the floor of the House has been on socioeconomic issues. AMA reference committee members are assiduous in subliminating their own personal opinions and reflecting the majority opinion deduced from the testimony given at the reference committee hearings. Sometimes the delegates do not feel the reference committee members have been accurate in their interpretation of the evidence provided in the hearing and sharp criticism ensues.

AMA elections are very competitive with active campaigning beginning several months before they take place. Delegates from states which have candidates on the ballot employ various means to promote their candidates and by the time the elections take place, a variety of badges and other gimmicks are in evidence.

Activity at an AMA meeting never ceases. Reference committees hold day-long hearings that have been known to go on into the evening. The committee members work through the night and into the morning. The printing takes place on a 24-hour basis. Daily bulletins are printed. State associations have breakfasts, lunches, and receptions. Hospitality rooms with the delegates acting as hosts and helping at the bar are open at various times for prelunch and predinner cocktails.

It is most unfortunate that the HMA members who attend the AMA meetings seldom visit the headquarters hotel to attend the meetings and learn how top-level policy decisions are made. This lack of interest was especially disappointing at the Las Vegas meeting where so many from Hawaii were present. I feel I have been fortunate to have Dr. George Mills working with me as alternate at the summer meetings. He has been very helpful and willing to divide the duties. The HMA presidents who have attended the annual sessions have shown considerable interest and I think they find this experience

helpful in the ensuing year. I believe that the expense involved is too great to send the president-elect to these meetings or to send the president to the winter session. The winter sessions are, however, becoming more active and the delegate could use assistance. However, in order to be meaningful, this assistance should come from someone familiar with the work of the House and the people involved. Adequate knowledge is not gained from attending just one or two sessions.

As your Delegate, I have attempted to vote in the manner I have thought you would want me to. However, this task would be easier if the delegates to the HMA were more active in sponsoring resolutions which would put the Association on record. At the coming two sessions of the AMA House of Delegates which take place before my term expires. I will be required to vote on many things. Only one item has been discussed with individual members and that is the AMA Disability Policy. It is most unfortunate that no one from Hawaii followed the discussions pertaining to this matter when it came up at the Las Vegas meeting. However, I feel that I have heard from enough members that I will be able to truly represent the feelings of the doctors of Hawaii when I vote on this subject.

However, as far as the so-called Millis report is concerned, the Hawaii doctors have not been sufficiently interested in this subject to form opinions and to establish policy. This report, if adopted, will completely change graduate medical education. One of its recommendations, for example, is to eliminate the present rotating internship. The proposal that medical students go directly into resident training certainly merits study. Other areas that need complete study before decisions can be made include the elimination of the general practitioner and substituting for him the "primary" physician. The "primary" physician would have residency training similar to that for a specialist. A graduate medical training would be under a "Commission" that would have representatives from the different fields including the public. It should be noted that these proposals were enthusiastically received by the physicians who attended the Medical Education Conference held in Chicago last February. While Hawaii's one vote will not change the outcome on the floor of the House, our opinions can perhaps influenced the votes of others if they are based on serious study and sincere interest in the future of medicine.

RICHARD D. MOORE, M.D.

*AMA Delegates' Reports*

No one appeared to testify.

Your Reference Committee reviewed and discussed this report and recommends the acceptance of this report with full support of our delegates at the AMA House of Delegates meetings.

**ACTION:**

**The Chairman moved adoption of this portion of the report. It was adopted.**

## MABEL L. SMYTH MEMORIAL BUILDING

The members of the Board of Management for 1966 were: Representing the Hawaii Medical Association, Dr. B. Allen Richardson, Dr. Donald C. Marshall and Dr. O. D. Pinkerton; representing the Hawaii Nurses' Association, Miss Charlotte Dennis and Mrs. Hazel Kim; representing The Queen's Hospital Board of Directors, Mr. A. J. Hebert.

On January 19, 1967, Dr. Richardson went off the Board and Dr. John Lowrey was appointed as alternate, and Mrs. Gladys Leong replaced Mrs. Cookson as alternate.

When the Bureau of Medical Economics moved to the Yee Hop Plaza the Hawaii Medical Association took over part of the office previously occupied by the BME and the remainder was made into two conference rooms. The Honolulu County Medical Society took over the old HMA office for its Medical Foundation.

Since the last report in April, 1966, major expenditures have totalled over $11,300.00:

| | |
|---|---|
| Air-conditioning Replacements | $4894.84 |
| Remodeling the 2nd Floor | 3596.42 |
| Furniture | 500.00 |
| Painting the Building (Outside) | 1825.00 |
| Painting First Floor Offices | 536.64 |

The Board approved a retirement plan for employees which is similar to the one in use by the Hawaii Medical Association. The final contracts are being processed.

A breakdown of the membership on the Nurses and Physicians Exchange as of December 31, 1966, was as follows:

| | | |
|---|---|---|
| Physicians | (increase 8) | 258 |
| Radio Page | (increase 6) | 100* |
| Registered Nurses | (decrease 8) | 80 |
| Practical Nurses | ( same ) | 30 |

The total number of calls processed was 201,700, an increase of 54,130 during the year.

Two projects are in the planning stage: (1) A Radio Page hook-up with The Queen's Hospital; (2) Intercepted Service for members who prefer that type of service. This equipment is very expensive and whether we would be able to give the service for anywhere near the rate our competitors supply it is a problem to solve. We are working on it.

A copy of the latest auditor's report has been placed on file in the HMA offices.

DONALD C. MARSHALL, M.D.

* Included in the 258 figure.

*Mabel L. Smyth Building Report*

No one appeared to testify.

Your Reference Committee next reviewed the Mabel L. Smyth Memorial Building Report. Your Reference Committee recommends acceptance of this report.

**ACTION:**

**The Chairman moved adoption of this portion of the report. It was adopted.**

## HAWAII COUNTY MEDICAL SOCIETY

The Hawaii County Medical Society held eleven professional meetings and three social meetings since the last report dated April 18, 1966. Average attendance was seventeen physicians.

Areas of major concern during the previous year were:

1. HMSA: Negotiations continue with HMSA but now at a state level.

2. DSS: All doctors who have not computed deductions for DSS have had their payment requests returned. This matter still has not been resolved. However, it is the official position of the Society, that DSS, and not the individual physicians, should compute the current and temporary discount.

3. WORKMEN'S COMPENSATION: Following hearings in Hilo, no final word has been received from Mr. Laureta's office with reference to final fee schedules.

RIGINALD S. CARVALHO, M.D.
*Secretary*

*Hawaii County Medical Society Report*

No one appeared to discuss this report.

Your Reference Committee next considered the Hawaii County Medical Society Report and recommends acceptance of this report.

**ACTION:**

**The Chairman moved adoption of this portion of the report. It was adopted.**

## HONOLULU COUNTY MEDICAL SOCIETY

This past year has continued to reflect the accelerating activity of the entire nation in the field of medicine, both from the point of view of the economist, the sociologist, and the politician.

The Honolulu County Medical Society activities have kept pace with this rapid movement of forces affecting our profession.

The Foundation for Medical Care is off the ground and is a living and growing force. It is small and has not yet imparted the maximum impact on the economy of the doctors. This is important to remember and I wish to stress that the struggle to make the Foundation strong and vigorous has not been won. It has enemies from without and they are determined to destroy it. We cannot afford to have attrition from within. Complaints have been voiced because of the level of the conversion factor. I do not wish to belabor the point at this time, but this is essential for all to understand. The conversion factor will be changed at the time that the Foundation becomes a factor in the total economy of the medical profession. Right now it is essential that we build.

Medical Plaza, Inc., has had a most frustrating year. Parking has been a bottleneck that has seemed impossible to open. At the present time it is very much alive and city planning seems to be taking a direction that will solve the vexing problem of where to put automobiles.

Medicare has developed some real problems in several areas. The Society undertook the task of reviewing the utilization of rural hospital facilities and the utilization of extended care facilities. This program is working well despite some seemingly rough spots. We also have appointed the Review Committee to Aetna for the purpose of reviewing questionable claims. We might mention that Aetna has been most cooperative and very helpful.

One of the most vexing problems brought about by Medicare has been the relationship of the physicians to the plantations. The demand by the plantations for rebate of Medicare fees has produced an almost intolerable situation. Honolulu County Medical Society studied the situation and has established a policy that will be a guide to the plantation doctor in his negotiations with his employer. This policy has been most forthrightly stated. The Society stands ready to assist the physician in his negotiations with the plantations.

HMSA has presented a continuing set of difficulties. The advent of the concept of "usual and customary" and "reasonable" fees appears to be filled with danger signals. Captivity under any name is repugnant to the profession. Escape from our previous condition of servitude has resulted in a new era of self-determination in that no longer are we tied to an arbitrary selection by an outside agency of the level of our economic life. Witness the acceptance of Workmen's Compensation of the concept of the RVS. How many years were we tied to HMSA schedules? Now we are free to make our own destiny. Let us protect that with all our vigor.

The internal workings of the Society have been effective. There have been some weaknesses in committee participation and these are being corrected. Physician participation has been good.

The Speakers Bureau of the Society has been notably successful and those doctors participating have made a major contribution to the improvement of the public image of the profession. Besides, I strongly suspect that the speakers have also had a lot of fun.

The BME has enjoyed an unusually successful year. Training programs for office assistants, advice to physicians on their finances, establishment of effective programs for estate management, and general help in the day-to-day business affairs have contributed much to the physicians of the Society. The growth of the Medical Dental Ledger Service in the BME filled a long-time need. Its volume alone attests to that. Further expansion of the BME into new areas of activity are being considered. It remains a subsidiary of the Society and under the direct control of the Society.

Our relationship with the legal profession has shown a growing maturity. This has been of benefit to every member and our maintenance of this relationship should have a very great effect on the cost of malpractice insurance. Many of the conflicts brought to the Medical Practice Committee could have been avoided. Additional efforts of the Society to instruct its membership will be needed in the future. The Medical Practice Committee is a strong and effective committee.

The growing population of our island has been reflected in the growth of our Society. We are well past the six hundred membership mark and we are welcoming new members regularly.

This is a period of change. The stresses associated with changes are inevitable. Our future as physicians and members of this Society will be determined by our ability and desire to participate in molding these changes and thereby contributing positively to the future and minimizing the stresses. The strength of the profession will be directly proportionate to the cohesiveness with which it can meet the challenges of the future.

GEORGE H. MILLS, M.D.
*President*

*Honolulu County Medical Society Report*

No one appeared to testify on the report.

Your Reference Committee reviewed and discussed the Honolulu County Medical Society Report and recommends acceptance of this report.

**ACTION:**

**The Chairman moved adoption of this portion of the report. It was adopted.**

## KAUAI COUNTY MEDICAL SOCIETY

Get ready for the "Change Age," this appears to be the theme for the Society for 1966.

With the start of the year, and throughout much of the year, repeated discussions were held in connection with the Hawaii Medical Service Association insurance contract, and the position the Society as a whole would take —solo or in concert with the other Societies of the Hawaii Medical Association with the final decision to go in concert.

With the advent of spring, the season for change, plans were made for the activation of the government Medicare programs which were to begin in July. First, in the line of speakers came Dr. Lummis who discussed the first two phases of the program, the Acute Hospital and the Home Care Pragram, the role of the Health Department as regulating agency for the Home Care Program. Later, discussions were held with the carriers for the program.

The Island of Kauai was host for the Interim Scientific Session of the Hawaii Medical Association for several days which was fruitful to all.

Among the many guests the Society was honored to hear was the President of the American Medical Association, Dr. Charles L. Hudson. Dr. Herbert Luke presented an instructive program on "Cardiac Resuscitation." Dr. Duke Cho Choy discussed "Medicine and Religion" and the role of a physician in this new field of medicine. In addition, he spoke on "Hypnotism, its History and Application in Medicine."

In keeping with the theme of change, the Society's membership likewise went through change, it lost and gained members.

This theme of change, it was evident, would be continued throughout the coming year and the society members were prepared to accept these as they were presented.

YONEMICHI MIYASHIRO, M.D.
*Immediate Past President*

*Kauai County Medical Society Report*

No one appeared to discuss this report.

Your Reference Committee reviewed and discussed the Kauai County Medical Society Report and recommends acceptance of this report.

**ACTION:**

**The Chairman moved adoption of this portion of the report. It was adopted.**

## MAUI COUNTY MEDICAL SOCIETY

The Maui County Medical Society began 1966 with 32 members and ended with 33 active members, with the addition of Dr. Dorothy Wood and Dr. Lawrence Allred, and the resignation of Dr. F. H. Tong, pending retirement.

Under the presidency of Dr. Kenneth Haling, the Society had six regular meetings in April, May, September, October, and December; all other meetings were brief sessions held after the regular Maui Memorial Hospital staff meetings.

Important business matters included adoption of Physician–News Media Publicity Ethics Policy and the 1965 Hawaii Relative Value Studies.

Guest speakers included Dr. Charles Hudson, President of the American Medical Association, who spoke at our September meeting.

A Christmas party for doctors and wives at the home of Dr. Allred and Kula Lodge ended the year. Dr. Edmund Tompkins announced his retirement effective January 1, 1967. Dr. Billie Fern Strother was inaugurated as the 1967 president at that time.

BILLIE FERN STROTHER, M.D.
*President*

*Maui County Medical Society Report*

The President of the Maui County Medical Society was present to discuss her report.

Your Reference Committee recommends acceptance of this report.

**ACTION:**

**The Chairman moved adoption of this portion of the report. It was adopted.**

## RESOLUTION NO. 19

Re: Full-time AMA President

WHEREAS, The duties of the President of the American Medical Association are becoming more numerous and more demanding; and

WHEREAS, The need for developing more continuity in the running of AMA's affairs is becoming greater; now, therefore be it

*Resolved,* That the Bylaws of the AMA be studied with the idea of changing them to provide for a permanent, full-time president; and be it further

*Resolved,* That the Hawaii Medical Association's delegate to the AMA be instructed to introduce a resolution consisting of the above three paragraphs at the AMA's 116th Annual Session.

Submitted by B. A. RICHARDSON, M.D.

*Resolution No. 19*

Your Reference Committee next discussed Resolution No. 19 regarding a full-time AMA President. Dr. B. A. Richardson was here to discuss this resolution. It was the unanimous opinion of your Reference Committee that it is in agreement with the principle of having a full-time AMA President and recommends the adoption of this resolution.

**ACTION:**

**The Chairman moved that the resolution be adopted.**

**Dr. Richardson spoke for the resolution, Dr. Moore spoke against it. It was not adopted.**

## RESOLUTION NO. 20

Re: Appointment of Physicians to Boards and Commissions

WHEREAS, The increasing complexity of government has made it necessary that many functions of government be guided by professional personnel serving in advisory capacities; and

WHEREAS, It is becoming more and more necessary that professional judgment is utilized to avoid costly mistakes in administration of the multiple programs involving medicine and government; and

WHEREAS, The Medical Profession is the only competent organization to make a determination as to competence in medicine; and

WHEREAS, The Medical Profession has always indicated its willingness to be of assistance in advice and counsel in medical matters; now therefore be it

*Resolved,* That the House of Delegates of the Hawaii Medical Association recommend that the Hawaii Medical Association be consulted by appointive authority, State, or City & County, prior to the making of appointments of medical personnel to positions requiring medical competence on Boards, Commissions, Advisory Committees, etc., other than classified positions in Civil Service; and be it further

*Resolved,* That copies of this resolution be forwarded to the office of the Governor of the State of Hawaii, the President of the Senate of the State of Hawaii, and the Speaker of the House of Representatives of the State of Hawaii, and to the office of the Mayor of the City and County of Honolulu.

Submitted by HONOLULU COUNTY MEDICAL SOCIETY

*Resolution No. 20*

Resolution No. 20 was discussed in the presence of Dr. Wilbur Lummis of the Health Department. After considerable discussion, your Reference Committee moves the adoption of this resolution.

**ACTION:**

**It was voted to add to the last resolved, after the word "Honolulu," "and to the County Chairmen of the neighbor islands."**

**The Chairman moved that the resolution be adopted. It was adopted as amended.**

**It was voted to adopt the report as a whole as amended.**

Your Reference Committee Chairman wishes to thank the members of the Committee for their diligent work, and for listening to the voluminous testimony so patiently and attentively.

The Chair requested permission to have Dr. Lee present the report of the Reference Committee on miscellaneous business out of order. Permission was granted.

# MISCELLANEOUS BUSINESS

Mr. President and Members of the House of Delegates:

Your Reference Committee met before an audience of interested physicians, committee chairmen, and guests and received testimony on the various resolutions and reports submitted to the Committee for consideration and recommendation. Having heard the discussion of the witnesses and having given careful consideration to all the testimony presented to it, your Reference Committee is pleased to make the following report:

## AMA-ERF COMMITTEE

This committee encourages physicians and others to contribute to medical education and research through the parent AMA Educational and Research Foundation. This

year it placed reminders in the monthly HMA bulletins encouraging gifts and was an enthusiastic observer of the Honolulu County Woman's Auxiliary's auction and dinner at the Hilton Hawaiian Village for this cause. It will place literature at the annual May HMA meeting and plans to show a movie on the foundation at the county medical society meetings when the movie is available from the AMA.

This year the contributions to AMA-ERF were increased over the prior year from 115 contributors who donated $2,745.08 to 195 contributors who donated $4,759.26. Further increase is still needed to reach the 1964-1965 level of $5,408.72.

Last year $12.00 from AMA-ERF was given to the University of Hawaii Medical School. This year the amount will be $241.19. The amount that will go to all schools will be $1,051,933.11.

DOUGLAS B. BELL, M.D.

*AMA-ERF Committee*

Your Reference Committee first considered the AMA-ERF Committee Report. No one appeared to discuss this report. Your Reference Committee recommends the approval of this report and commends the Committee for its excellent contribution to a worthy cause.

**ACTION:**

**The Chairman moved adoption of this portion of the report. It was adopted.**

## ASSOCIATION OF PROFESSIONS COMMITTEE

The committee did not meet during the year 1966-1967, and nothing was referred to it for consideration. This was the first year the Chairman had been on the committee, into which position he was pressed in spite of pleading lack of time, which was a matter of some moment until February-March, 1967. As of this writing I am unable to predict the matter of availability of time during the period July, 1967, to February, 1968, but would be willing to continue the Chairmanship provided that should time become a problem, another physician would be appointed to the position.

Although nothing was done during the year, it is the opinion of your chairman that the purposes of the committee are valid and important, and that the committee should be continued, with all possible energy and enthusiasm.

GEORGE F. SCHNACK, M.D.

*Association of Professions Committee*

An extended discussion of the subject was had and your Reference Committee feels that the mechanism to achieve the goals of this committee should be attained as soon as possible. It is recommended that this committee be continued and that the goals of this committee be attained in the near future.

**ACTION:**

**The Chairman moved adoption of this portion of the report. It was adopted.**

## CAREERS COMMITTEE

The Fifth Annual Careers Day Program was the major undertaking of this committee. Hosted by 60 physicians and hospital exhibitors, 120 high school juniors and seniors were afforded a glimpse of the many facets involved in hospital care, and exposed to physicians in a personal and relaxed atmosphere. These students were selected through the cooperative efforts of the various high school counselors who met with the committee earlier. The purpose of this program is to foster interest and offer encouragement among academically able students to choose a career in the medical field. Most of the participating physicians felt that this was a worthwhile program and should be retained. This was also the first year in which the program was given the benefit of a full-page spread in the *Honolulu Advertiser*.

In cooperation with the Department of Education's Academically Talented Children's Program, 12 intermediate school children from culturally deprived homes, but of above average intelligence, were permitted to attend a selected number of the exhibits on a trial basis. This means of broadening their experience by community contact is difficult to assess, but both host physicians and students were enthusiastic as to its worth.

Copies of *Horizons Unlimited*, the AMA handbook describing career opportunities in medicine and allied fields, were distributed to all high school counselors throughout the State as a reference source.

The following letter was received from Dr. Boyden of Kauai: "As you may know Kauai has been sending students to the Careers Day since the inception of the program and our Society has been paying one-half of their transportation costs. We feel that the students should pay the other half and we feel also that the County Societies should pay the balance rather than the Association since this is about the only way we have any representation in the program. This might be brought up again at the annual meeting."

An up-to-date list of students attending mainland medical schools is being maintained under sponsorship of this committee and is available to all physicians. This year's list shows that 67 Hawaii students are enrolled in 33 mainland medical schools. Only nine schools failed to reply to our letter asking for this information.

RECOMMENDATIONS: (1) The Careers Day Program should be continued. (2) Since there has been disagreement in the past as to how the cost of transporting students from the neighbor islands to the Careers Day Program should be met, it is the recommendation of this committee that each county medical society decide this matter for itself. However, the HMA should continue to appropriate sufficient funds to be available if assistance is applied for in advance.

BUDGET:

| | |
|---|---|
| Meals for students and physicians | $250 |
| One-half of air fares for 15 students | 240 |
| | $490 |

JAMES B. H. YOUNG, M.D.

*Careers Committee*

Your Reference Committee, together with the Chairman of this Committee, had a full and complete discussion of the subject and recommendations. It is recommended that the two recommendations and budget of this committee be accepted.

**ACTION:**

**The Chairman moved adoption of this portion of the report. It was adopted.**

## DISASTER COMMITTEE

The committee held only one formal meeting involving the entire committee during the year. Most of the work and the planning was done on an individual basis or in small groups. Another meeting of the entire committee is planned for May, 1967, to talk over the year's progress.

The ongoing programs of Medical Self-Help, Red Cross First Aid, emergency medical stockpiling, and the PDH (Packaged Disaster Hospital) were supported and encouraged. A combined training program of Medical Self-Help and Red Cross First Aid was held on the neighbor islands for instructors in order to increase their numbers. The Medical Self-Help program is now in the regular curriculum of most Hawaii public and private schools, usually at the 10th grade level. Since March, 1963, an estimated 27,000 people have received Medical Self-Help training in Hawaii.

All major Honolulu hospitals have been advised in writing of the desirability of installing radio communica-

tion equipment in order to establish a radio communication network which would be useful in times of disaster. Progress has been slow in this program, principally because of the cost of the radio transmitter equipment required, and the fact that this equipment is of limited value during normal periods.

Assignments of HCMS doctors to ten disaster teams scattered over the Island of Oahu were made in late 1966 by the HCMS with the cooperation of the State and County Health Departments. Where feasible, similar assignments should be made on the neighbor islands. Keeping such assignments current is very difficult, but it is a necessary task which should be assumed by each county society.

A milestone in achievement for the Hawaii disaster planning group was the signing of the "Statement of Understanding" by Governor Burns on December 7, 1966. This agreement would facilitate cooperative relationship for patient care between military and civilian medical communities in case of natural disaster on Oahu. This plan could serve as a model for other county societies or for interstate cooperation, when and if the need for such is established.

There were two major disaster exercises during this reporting period. Perhaps the most comprehensive and largest exercise ever held in Hawaii was the CDEX-66, on November 30, 1966. The exercise involved all the islands and received much support from high level officials, including the Governor of Hawaii and the Mayor of Honolulu. All segments of the medical disaster plan were fully exercised.

The second large exercise was sponsored by the Hawaii Hospital Association and was held on March 30, 1967. This exercise also involved many other organizations, such as the military, HCMS, Police Department, Civil Defense Agency, State Health Department, and, of course, all the major Honolulu hospitals. Approximately 200 made-up casualties were sorted, treated, and transported from the original simulated disaster site at McKinley High School to one of the Honolulu hospitals.

As a consequence of last year's HMA Disaster Committee's recommendation for closer affiliation with the other western states in disaster preparedness, a meeting between the California Medical Association Disaster Chairman and your Chairman has been scheduled in San Francisco on April 4, 1967. The purpose of this meeting will be to work out a practical disaster readiness plan of mutual assistance between CMA and HMA. A draft plan will be presented to the CMA Disaster Chairman at that time. It is hoped that a final plan can be approved and signed at the CMA annual meeting in Los Angeles on April 17.

RECOMMENDATIONS: (1) That HMA continue to work with CMA and other western state medical associations to obtain workable plans of mutual medical assistance during periods of major emergency. (2) That plans be made for intra- and inter-state (e.g. with California) disaster exercises, utilizing the airlines for transportation of supplies and medical manpower. (3) That all county societies be urged to update their disaster plans and medical manpower assignments at least annually. (4) That all HMA members be encouraged to promote and take an active part in all existing disaster medical training, emergency medical stockpiling, and disaster exercise programs as their time permits. This should include the building of friendly working relationships with all the paramedical groups and volunteer agencies in Hawaii. (5) That HMA Disaster Committee continue to urge the hospital administrators of Honolulu and the neighbor islands to obtain and install radio communication equipment for general as well as emergency use.

CASIMER JASINSKI, M.D.

*Disaster Committee*

A full and complete discussion of the subject was had with the Chairman of this Committee and a representative of the State Department of Health.

Your Reference Committee feels that the report should be accepted and commends the Committee for their progress over the past year. It is recommended that the report be accepted and that recommendations Nos. 1, 2, 3, and 4 be accepted. It is recommended that recommendation No. 5 be amended as follows:

Recommendation No. 5: That the Hawaii Medical Association Disaster Committee continue to urge and guide the hospital administrators of Honolulu and the neighboring islands to attain and install communication equipment for general as well as for emergency use after investigating the cost, available funds for this equipment, and other available resources such as ham radio operators from both the physician and lay community.

**ACTION:**

**The Chairman moved adoption of this portion of the report. It was adopted.**

## HAWAIIAN ACADEMY OF SCIENCE COMMITTEE

The major activity of the committee during the year was judging the Tenth Hawaiian Science Fair and giving the prizes provided by the HMA. These included the following:

$50.....Lorna May Sakado
Laupahoehoe High School
"Using Plant Lichtins to
Identify Blood Groups"

$25.....Nona Sakata and Maxine Suder
Kamehameha Schools
"Analysis of Amino Acids
in Human Hair"

$25.....Donald Chung
Kaimuki Intermediate School
"Antibiotics—Penicillin"

The Fair was judged by Drs. Robert Jim and Robert A. Nordyke. This year the prize money was more in line with the awards of other agencies.

There has been considerable discussion regarding the necessity of this committee as a separate committee. Since its only real function appears to be the judging of the Science Fair and some communication between the HMA and the Hawaiian Academy of Science which has been rather minimal, it is therefore recommended that the committee be abandoned and that its functions be transferred to other existings committees. The most likely one for giving Science Fair awards would probably be the Awards Committee and it would seem useful for the representative of the HMA to "ISSEC" to sit on the Awards Committee also although this would not be necessary.

The budget for the work this committee has been doing, mainly the Science Fair Award, is $150, and it is suggested that this be continued for next year if this is transferred to another committee.

RECOMMENDATIONS: (1) That the Hawaiian Science Fair Committee be discontinued as a separate committee. (2) That the functions of the Hawaiian Science Fair Committee be absorbed by the Awards Committee. (3) That the budget for the Hawaiian Science Fair Committee be transferred to the committee which takes over its duties. (4) That the HMA representative to ISSEC be asked to serve on the committee which absorbs the duties of the Hawaiian Science Fair Committee.

BUDGET REQUEST:

| | |
|---|---|
| Support of the Hawaiian Science Fair | $100.00 |
| Prizes for the Science Fair | 100.00 |
| | $200.00 |

ROBERT A. NORDYKE, M.D.

*Hawaiian Academy of Science Committee*

A complete discussion of the report was heard and your Reference Committee feels that this Committee may be abandoned in the manner prescribed without jeopardizing the goals of the Committee. It is recommended that all four recommendations presented by the Committee be accepted, and that this Committee's functions and budget be delegated to the Awards Committee.

**ACTION:**

**The Chairman moved adoption of this portion of the report. It was adopted.**

## JAPANESE SPEAKERS BUREAU

The committee held three meetings earlier in the year to work out a whole year's schedule of speakers and topics. This was distributed to each member as well as to Radio Station KOHO and the *Hawaii Times*. The Monday night "People Speak" program from 7:10 P.M. to 8:00 P.M. is one of the most popular call-in programs in Hawaii and is heard on all islands. It has been an effective bulwark against the medical quackery disseminated by the Japanese language papers and radio stations by health faddist organizations.

Special credit should be given to Dr. Shigeo Natori who spoke on radio stations KZOO and KOHO for fluoridation in the face of an overwhelming antifluoridation sentiment in the Japanese community. Drs. Goshi, Natori, and Yokoyama are also to be commended for their fluoridation articles which appeared in both Japanese papers.

Several of the members viz Drs. Fukumura, Tanaka, Goshi, and Yokoyama have contributed to a biweekly medical question-and-answer column appearing in the *Hawaii Times*. The assets of this Bureau are high morale, individual versatility in the language, and dedication to health education of a segment of population which is quite susceptible to quackery and health faddism.

Future projects for the Bureau include increased rapport with the Japanese press, and radio, possible appearances on both KOHO and KZOO and inauguration of weekly question-and-answer columns in both the *Hawaii Times* and *Hawaii Hochi*.

KAZUSHI TANAKA

*Japanese Speakers Bureau Committee*

A discussion of the report was heard and your Reference Committee commends this Committee for its contributions in this area. It is recommended that the report be accepted.

**ACTION:**

**The Chairman moved adoption of this portion of the report. It was adopted.**

## MEDICINE & RELIGION COMMITTEE

The committee has had an interesting year. We were privileged to have Dr. Paul McCleave, head of the AMA Department of Medicine and Religion, appear before a meeting of ministers and physicians, giving a talk on "The Paradoxes of Modern Medicine."

Recognizing a need for ministers and doctors to get to know one another better, a group of five ministers and five doctors has been organized. This group is meeting for an hour once a month, carrying on discussion on topics selected by its constituents. This will be a continuing activity which promises to make big strides in promoting better understanding and working relations between these professions. Additional groups will be set up in the near future.

The Honolulu Council of Churches established a volunteer chaplaincy program at The Queen's Hospital under the guidance of Mr. Stanley Kain. We recognize the great value of this program and have discussed its operation with Mr. Kain. One of our committee members sat in on an evaluation meeting of the chaplaincy program with Mr. Gibbs, Assistant Administrator of The Queen's Hospital. The full cooperation of our Committee was offered for any promotion of educational programs. Mr. Gibbs would plan for the nursing staff.

Visits to the county medical societies of Kauai and Hawaii have been made by the chairman of the committee. It is hoped that interest and activity in establishing better working relations between ministers and doctors will result. Dr. Paul McCleave visited Maui and plans were laid to organize a group of doctors and ministers. Monthly breakfast meetings are held at the hospital to discuss problems of mutual interest. Under the chairmanship of Dr. Sowers, Maui has developed an ongoing program of merit involving about 20 participants.

Dr. Maurice Howell represented our committee on a panel for the Woman's Auxiliary meeting where the film "The One Who Heals" was shown. He discussed the activities of our committee and answered general questions on our functions.

The chairman of the committee was privileged to attend the first Conference of State Chairmen of the Committee on Medicine and Religion, sponsored by the AMA. This was held in Chicago on February 18-19, 1967. This offered a valuable opportunity to compare our activities with those of other states. It can honestly be stated that our program is far ahead of many of the other states. However, we have much to do to catch up with some. Suggestions offered during the conference included the editing of a manual for doctors on various religion viewpoints on medical practices; a manual for ministers on routine hospital procedures; more films and filmstrips on minister and doctor relationships; general education of the public on the willingness of doctors and ministers in working together for the patient's good.

An area which will be emphasized is that of training of ministers in pastoral counseling. Mr. Stanley Kain of the Honolulu Council of Churches is organizing the program. We shall be working in close conjunction with him and hope that physician participation in the program will be a vital one.

We feel that much remains to be done to augment cooperation and understanding between ministers and doctors. Our committee feels that it has been a privilege to work in this area the past year.

RECOMMENDATIONS: (1) That publication of the handbook approved by the House of Delegates be held in abeyance pending national action. (2) That the small discussion group meetings be continued throughout the next year.

BUDGET REQUEST:

| | |
|---|---|
| Evening Meetings | $ 30.00 |
| Travel | 200.00 |
| | $230.00 |

DUKE CHO CHOY

*Medicine and Religion Committee*

After a complete discussion of the report, your Reference Committee feels that this report should be accepted. It is recommended that we accept this report, its two recommendations, and the budget requested.

**ACTION:**

**The Chairman moved adoption of this portion of the report. It was adopted.**

## MESSAGE OF THE MONTH COMMITTEE

During 1966-67, the committee composed and distributed 12 monthly Messages:

| | |
|---|---|
| May | — People Who Think They Should Use Laxatives |
| June | — Those Affected By Summer Boredom |
| July | — Those Interested in Family Planning |
| August | — People Who Think They Need Vitamins and Minerals |
| September | — Those Who Should Check Their Immunization Record |
| October | — Fluoridation |
| November | — Those Who Have Positive Tuberculosis Tests |
| December | — Parents of Adolescent Girls |
| *1967* | |
| January | — Dental Health Week |
| February | — Those Who Are About To be Poisoned |
| March | — To The Tired People of Hawaii |
| April | — People Who Get The "Blues" |

There were approximately 140,000 Messages distributed each month. The Hawaii Dental Association and the Hawaii Tuberculosis Association sponsored one Message

each. The Cancer Society has reserved the month of July.

The success of this program depends, to a large extent, on the faithful assistance of the Woman's Auxiliary.

These Messages continue to receive favorable response from patients and it is recommended that this program be continued with the full support of the Hawaii Medical Association.

BUDGET:

Printing ..... $2,070

WILLIAM F. MOORE, JR., M.D.

*Message of the Month Committee*

A complete and critical discussion of the subject was had among the committee members and your Reference Committee feels that this committee should be commended for its activities in public relations. It suggests that this committee seek further funds from allied health agencies to supplement the cost of the messages of the month. This committee also suggests consideration of having a message every two months instead of monthly. It is recommended (1) that the report and budget be accepted for the next fiscal year. (2) That the messages be critically selected and consideration be given to distribution every two months instead of monthly. (3) That the committee seek funds from allied health agencies to supplement the cost of the messages.

**ACTION:**

**The Chairman moved that the resolution be adopted. It was adopted.**

## NEWS MEDIA COMMITTEE

The committee did not hold any formal meetings but its work continued on as in the past. Dr. Gene Ahern has continued to write his "Keiki Kare" column for the *Honolulu Star-Bulletin*. The weekly press release which is tied in with the weekly television programs is written by Mr. Lytle. It is used sporadically by several of the newspapers and quite regularly in Hilo's *Hawaii Tribune Herald*. The *Garden Island News* has a new editor, Mrs. Jean Holmes, who used the release once. After a personal contact with the paper, it was learned that they found the releases very interesting and promised to use them as soon as they develop enough advertising to justify extra editorial copy.

Considerable copy was sent to the Japanese papers during the fluoridation campaign. Biweekly releases in Japanese continue to be given to the *Hawaii Times*. The *Hawaii Hochi* has not been given this service due to lack of time and people who can write in Japanese.

The press awards were increased this year to provide for a second winner. Precedent for this was set last year when the "Mark Waters Story" received a special award. Only one paper, the *Advertiser*, submitted entries. Two entries will be selected from the fourteen submitted and the awards will be presented at the Annual Meeting Banquet. In addition to the winners, Lois Taylor and "Riv" Tobin will be invited to the banquet. The chairman of the Arrangements Committee, Dr. Chinn, has asked for special coverage for this year's banquet.

The chairman of this committee continues to write the "Notes and News" column for the HAWAII MEDICAL JOURNAL. Reviewing the news clips that come in each week has provided a natural tie-in between the two duties.

One new accomplishment took place. On November 1, all the news media were provided with a list of people to contact if they want help in clearing and preparing stories. The list is composed of the following:

MEMBERS OF THE NEWS MEDIA COMMITTEE
(HAWAII MEDICAL ASSOCIATION)—1966-67

University Representatives:
R. W. Noyes, M.D., Ph. 918-640
University of Hawaii
2539 The Mall
Honolulu, Hawaii 96822
Donald Char, M.D., Ph. 918-111
University of Hawaii
1710 East-West Road
Honolulu, Hawaii 96822

The Queen's Hospital Representatives:
Morton Berk, M.D., Ph. 510-461
1133 Punchbowl Street
Honolulu, Hawaii 96813
Robert Peyton, M.D., Ph. 510-461
1133 Punchbowl Street
Honolulu, Hawaii 96813

St. Francis Hospital Representatives:
Herbert Y. H. Chinn, M.D., Ph. 560-139
250 Alexander Young Bldg.
Honolulu, Hawaii 96813
Henry H. C. Fong, M.D., Ph. 991-771
1415 Kalakaua Avenue
Honolulu, Hawaii 96814

Kuakini Hospital Representatives:
Edward Yamada, M.D., Ph. 700-788
1126 12th Avenue, Room 102
Honolulu, Hawaii 96816
Victor Mori, M.D., Ph. 564-431
1040 South King Street, Suite 404
Honolulu, Hawaii 96814

Kapiolani Hospital Representative:
Satoru Nishijima, M.D., Ph. 513-795
1024 Piikoi Street
Honolulu, Hawaii 96814

Castle Hospital Representative:
J. I. F. Reppun, M.D., Ph. 242-161
45-461 Pua Inia Street
Kaneohe, Hawaii 96744

Public Relations Committee Chairman:
Andrew C. Ivy, Jr., M.D., Ph. 574-546
839 South Beretania Street
Honolulu, Hawaii 96813

Hawaii County Representative:
William Bergin, M.D., Ph. 53-378
P. O. Box 606
Hilo, Hawaii 96720

Kauai County Representative:
R. J. Warner, M.D., Ph. 386-455
Waimea Clinic
Waimea, Kauai 96796

Maui County Representative:
Milton M. Howell, M.D., Ph. 442-333
Hana, Maui 96713

Children's Hospital Representatives:
Calvin Sia, M.D., Ph. 567-067
1350 South King Street, Room 300
Honolulu, Hawaii 96814
Carl H. Lum, M.D., Ph. 966-221
1441 Kapiolani Blvd., Suite 608
Honolulu, Hawaii 96814

Kaiser Hospital Representative:
Alexander Roth, M.D., Ph. 995-811
1697 Ala Moana Blvd.
Honolulu, Hawaii 96815

Commissioner:
Francis T. Oda, M.D., Ph. 564-431
1040 South King Street, Suite 404
Honolulu, Hawaii 96814

Chairman:
Henry Yokoyama, M.D., Ph. 992-621
1507 South King Street, Room 201
Honolulu, Hawaii 96814

Vice Chairman:
Benjamin Tom, M.D., Ph. 564-431
1040 South King Street, Suite 404
Honolulu, Hawaii 96814

Hawaii Medical Association Representatives:
Mr. Hugh Lytle, Ph. 567-702
Public Relations Counsel
510 South Beretania Street
Honolulu, Hawaii 96813

Mr. Patrick Godfrey, Ph. 567-702
Administrative Assistant
510 South Beretania Street
Honolulu, Hawaii 96813

RECOMMENDATIONS: (1) That the past activities of the committee be continued. (2) That the list of resource people for the news media be checked and, if necessary, revised. (3) That a second journalism award continue to be given.

BUDGET:

| | |
|---|---|
| Engraving of perpetual trophy | $ 4.00 |
| Cash Award (first) | 150.00 |
| Trophy (first) | 24.00 |
| Engraving of Trophy (first) | 16.00 |
| Cash Award (second) | 50.00 |
| Trophy (second) | 10.00 |
| | $254.00 |

HENRY N. YOKOYAMA, M.D.

*News Media Committee*

A discussion of the report among the committee members was heard and your Reference Committee recommends the approval of the report, its recommendations, and budget.

**ACTION:**

**The Chairman moved adoption of this portion of the report. It was adopted.**

## NURSES COMMITTEE

The committee has held two formal meetings during this fiscal year, October 31, 1966, and November 28, 1966. Two other meetings have been scheduled only to be cancelled due to the inability of the physician members to attend. The committee of doctors has been expanded by inclusion of nonphysicians as consultants and participants. Mrs. Cookson, Miss B. Sawyer, Sister Alberta, Miss Tacke, Miss Edwards, and Miss Imada, have attended, representing various nurse interests. The Hawaii Hospital Association has agreed to send representation to our next meeting as has the University of Hawaii's Nursing School. We feel that by including these groups the discussions will have more meaning and a greater chance of accomplishing some realistic goals.

The committee was originally charged with the recommendation from the House of Delegates that the Diploma Schools be fostered and should not be closed. Unfortunately, that recommendation has not had any effect as the last of the Diploma Schools closes with the graduation of the last class at Queen's. The University is attempting to fill the need with their two types of programs and have stated that in the near future they will have caught up with the needs. They also feel that the training being offered will provide a far superior nurse product than that presently existing.

The goals of the committee were defined at our first meeting as follows:

1. To serve as a means of continuing communication between the state Nurses Association and the state Medical Association and to suggest and coordinate joint activities of the two organizations.
2. To identify and consider problems and trends in patient care directly affecting practice and other areas of mutual concern to physicians and nurses.
3. To consider the implications of joint decisions of the two organizations and assist in their interpretation.
4. To consider the implications of pertinent activities, policies, and statements undertaken individually by the two organizations and assist in their interpretation.
5. To report and make appropriate recommendations to the respective boards of directors of the two organizations.

At the second meeting, these goals were compared with goals of other secular organizations.

The Patient Care Committees of the various hospitals were contacted and asked to send participants to subsequent meetings. The Hospital Committee of HMA was asked to attend or send representation. These have all replied favorably.

Some of the current problems which were discussed include:

1. The Nurses Role—Relationship of Nursing Personnel within Nursing Service.
2. Intravenous therapy to be administered by the nurses.
3. Closed cardiac resuscitation.
4. Nonnursing personnel in hospitals.
5. The Nurses Practice Act.
6. Patient care.
7. Standards for organized nursing service.
8. The team care concept.

It is hoped that another meeting can be scheduled in May at which time we can discuss with the University Nursing School representatives the needs of the state and how they anticipate meeting those needs in the future years.

RECOMMENDATION: (1) That in view of the increasing importance in the role of nurses as members of the health care team, that the assistance of the Public Relations Committee be obtained in developing an educational program to make the physicians aware of the changes taking place.

ROBERT G. HUNTER, M.D.

*Nurses Liaison Committee*

Your Reference Committee considered the Nurses Liaison Committee's report and after a lengthy discussion, felt that all means to obtain the goals of the committee be given full support. Your committee felt that the need for continued and improved doctor–nurse relationship is needed and desired. It is recommended that (1) the report and its recommendations be accepted, (2) the committee should continue to explore all means to attain the goals outlined in its report, and (3) the HMA, together with the Hawaii Nurses Association and University of Hawaii School of Nursing, discuss and amend the nurses' curriculum presently available for the mutual benefit of all concerned.

**ACTION:**

**The Chairman moved adoption of this portion of the report. It was adopted.**

## OPERATION PACIFIC COMMITTEE

There has been only one request for interim help during the past year—Samoa asked for help in covering Ob-Gyn. The short notice did not provide sufficient time to find a volunteer.

Dr. Charles Judd in Western Samoa has requested help from specialists who may be passing through his territory. He stated, "I can give them plenty of work but no pay." He has also requested sample drugs. Some have been sent and others are being collected and stored prior to shipment. The Woman's Auxiliary is handling this.

With some modification in the medical set-up of administration of the Trust Territory, it is likely that we may become active there during the coming years.

At a recent meeting with Dr. R. Y. Suehiro, Program Director of the East-West Center, a pooling of available manpower (East-West Center School of Public Health Biomedical Center and HMA) was suggested. Thus, we could plan programs of lectures, teaching, and inservice instruction and fill the need from a common pool, much better than any one alone could do. Between now and May, Dr. Suehiro will make an outline of the proposed program of aid and instruction for the Trust Territory and possibly other areas of the Pacific.

A list of local physicians who have assisted in the "Kokua Samoa" program as well as others who have shown interest has been submitted to him. We are in hopes that we may develop a well-rounded program of instruction. Financing for this project is available through the East-West Center. It is expected that volunteers will receive a stipend as well as transportation. The proposed tour is for two weeks. No arrangements are made for families.

RECOMMENDATIONS: (1) That the HMA continue to support and publicize the needs of Dr. Judd, and (2) that the HMA work with the East-West Center to develop programs in the Trust Territory.

THOMAS RICHERT, M.D.

*Operation Pacific Committee*

Your Reference Committee heard the historical background of this committee and feels that this committee's report and two recommendations should be accepted.

**ACTION:**

**The Chairman moved adoption of this portion of the report. It was adopted.**

## PUBLICATIONS COMMITTEE

The committee assisted the editor of the HAWAII MEDICAL JOURNAL in the selection of articles for publication as one of its regular duties.

Special projects included publication of the anniversary issue. The committee, ably assisted by Miss McCaslin and Mr. Lytle, organized a special issue of the HAWAII MEDICAL JOURNAL commemorating the 25th anniversary of the JOURNAL, and honoring Dr. Arnold, Jr., for his 25 years as Editor of the JOURNAL. The committee also put on a program at the October meeting of the Honolulu County Medical Society honoring Dr. Arnold, Jr., for his service to the Medical Association during his 25-year tenure as Editor of the JOURNAL. A properly engraved silver wine cooler was presented to Dr. Arnold by the Hawaii Medical Association at this event.

The committee met several times to discuss a proposal from *Pacific Medicine and Surgery* that this journal and the HAWAII MEDICAL JOURNAL be combined. After considerable discussion, it was recommended that it would not be advantageous for the HAWAII MEDICAL JOURNAL to merge with *Pacific Medicine and Surgery*, published by the Pan-Pacific Surgical Association.

No new duties and no change in procedural rules are recommended for the coming year.

RECOMMENDATIONS: (1) That Harry L. Arnold, Jr., be again commended for his excellent work and untiring efforts and be reappointed Editor of the HAWAII MEDICAL JOURNAL.

ELDON R. DYKES, M.D.

*Publications Committee*

A discussion of the report was heard and your Reference Committee feels that the committee should be commended for its efforts in assisting the editor of the HAWAII MEDICAL JOURNAL. It is recommended that the report and recommendation be accepted.

**ACTION:**

**The Chairman moved adoption of this portion of the report. It was adopted.**

## PUBLIC RELATIONS COMMITTEE

The committee has experienced a comparatively quiet year. The splitting of subcommittees from the Public Relations Committee into separate independent committees has proved a very successful idea. They have maintained their activities well during the past year. Much excellent public relations has been gained by our better-than-ever television program on the Educational TV stations. The necessity of an active news media program has diminished since both papers are writing excellent health education articles voluntarily. They have sought help from our committee frequently. The medical message of the month has continued to give maximum distribution at a minimal cost. Even if the message is not always read by the patient, it is felt that the fact that it is present in the doctors' billing has value. A most active program during the past year was the fluoridation program in October and November. Although it was unsuccessful in producing legislation for the City and County of Honolulu, I feel greater public acceptance and awareness was engendered. A copy of the fluoridation committee report which demonstrates a mileage of public relations activity that was gained merit perusal by the delegates.

We are presently studying doctor–patient relationship and doctor–doctor relationship and have initiated a non-society member questionnaire and several other programs in improving public relations in this area.

I would recommend continuing the same budget for 1967-68 fiscal year.

BUDGET REQUEST:

| | |
|---|---|
| Conference Expense | $ 550.00 |
| Counsel | 6,000.00 |
| Miscellaneous Newspaper Ads | 100,00 |
| MSEA Dues | 10.00 |
| Miscellaneous Flyers | 100.00 |
| Miscellaneous Printing | 50.00 |
| Miscellaneous | 100.00 |
| TOTAL | $6,910.00 |

ANDREW C. IVY, JR., M.D.

*Public Relations Committee*

A discussion of the report and budget was heard and your Reference Committee feels that this important committee's activities should be continued. It is recommended that the report and budget be accepted.

**ACTION:**

**The Chairman moved adoption of this portion of the report. It was adopted.**

## QUACKERY COMMITTEE

The function of the committee is to acquire and disseminate information regarding health quackery to the proper authorities in the State in an effort directed at the suppression of such quackery. It is a committee without legal power or budget. In the past year, it has met twice, and has discussed the following:

(1) Radio programs sponsored by a local health spa—which appear to constitute the practice of medicine. These are currently under investigation by the Department of Health. (2) A mechanical device for treatment of the skin sold in a local department store. This has been removed from sale. (3) A Japanese tea sold with the claim that it prevents development of cancer. Health Department officials are currently gathering evidence in this matter. (4) A papaya concentrate for which remarkable claims are made. This is under investigation by the Department of Health. (5) The Profit Protection Program and Treatment, a harebrained scheme by an emotionally disturbed man who was trying to enlist insurance companies nationwide to subscribe. This scheme would allegedly prolong life in heart and cancer patients, thereby allowing the insurance companies to collect premiums longer. The scheme has been withdrawn. (6) Better liaison with the Department of Health. The Director of the Department of Health was present at one meeting and our mutual problems and aims were discussed. (7) The use of Laetrile and urinary gonadotropin levels for detection of cancer by Beard Biochemistry Laboratory in Fort Worth, Texas. A letter discussing a case was sent to the laboratory in an effort to get more evidence regarding this interstate cancer quackery. The evidence will be turned over to the F.D.A. A letter of inquiry re the laboratory and its mentor was sent to the AMA and information was received that the owner has been successfully prosecuted. (8) Nite-Dri International, a device for cure of enuresis, is now being looked into. This is probably a legitimate enterprise. The AMA sends out a form letter to inquirers advising that the basic concept has some merit, the AMA recommends its use under the direction of a physician.

RECOMMENDATION: (1) It is recommended that the committee be provided continuity for next year in order to pursue the activities now under investigation.

W. H. SAGE, M.D.

*Quackery Committee*

A brief discussion of the report by its Chairman was heard and your Reference Committee feels that its activities and progress should be commended. It is recommended that the report and its recommendation should be accepted.

**ACTION:**

**The Chairman moved adoption of this portion of the report. It was adopted.**

## TV-RADIO COMMITTEE

Definition: The function of the committee is to disseminate medical information as well as render information concerning the medical profession itself to the laity. Recognizing the effectiveness of this medium in reaching the public, all attempts are made to create a good image of the medical profession as a whole. No attempt is made to promulgate any one individual physician or any particular medical specialty.

Summary of the Year's Activity: In order to appreciate the present status of the committee's function and performance, a brief resumé of its development is necessary. The medical profession first participated in television programs in January of 1954 and through that particular year produced, on the average, one monthly program. These were live telecast shows. As the time went by, it became obvious that the popularity of the programs was gaining momentum. In a very early survey it was estimated that some 60,000 to 70,000 viewers were available for each program. The initial format which dated back to 1954 had its ups and downs until 1962 when a major change in the format was undertaken. This consisted of audience participation by telephone communications with the television station, which was KTRG-TV, Channel 13, with Mr. Gordon Burke as the moderator. Further, this program was conducted on a weekly basis and initially enjoyed immense success and popularity. However, because of the limitation of transmission of the station that the program was associated with plus the loss of prime time for its telecasting, the program waned to a very low ebb in the spring of 1966. At this time, the committee was alerted to the deterioration of the program and plans were made to either drop the show entirely or seek other televsion stations and develop a new format. NBC, ABC, and CBS were contacted and, because none of these major networks was willing to provide prime time (6 p.m. to 11 p.m. on any given day) plus the fact no free time was available, it was decided that the channel that would most adequately suit our needs would be KHET, a partially Federal subsidized network with a philosophy more suited to our purpose. In August of 1966, Mr. Eblen was contacted and our intentions were presented to him. At the first meeting a glimmer of hope of getting the medical program rejuvenated was found. As the months went by and further negotiations developed, we were able to secure prime time on a very desirable day of the week, namely, Wednesday at 9 p.m. to 10 p.m. Further, a production director, Mr. Wendell Jones, was assigned to our committee to help integrate studio facilities, including audio-visual aids, with the participating panelists. The last Sunday of November of 1966 was the last show with KTRG-TV, and a continuous performance dating back to 1962 came to a close. On January 4, 1967, the show entitled "Medically Speaking" with an entirely new format had its debut. From its onset it enjoyed a tremendous response. Both participating physicians and television viewers were gratified.

In conjunction with the new format, committee members became active participants in the planning of each particular program. Each member was assigned as a coordinator, depending on his interest or specialty, for each program and had full control of the picking of the panelists, subject matter, and, in general, seeing that the assigned program ran off smoothly. Thus far, the system has worked out quite satisfactorily. Needless to say, without the cooperation of the committee members, the present series would not have enjoyed the success as it has thus far.

The continuing success of the television program will ultimately depend upon the amount of interest as well as the degree of cooperation among the committee members, particularly those who participate in the program. Further, there is no particular written contract with the present television station and severence of affiliation can be executed at any time by the present network facilities, if and when they feel that the program has either lost its impact or has deteriorated. This should not come to pass as long as the HMA members are willing to participate and devote their time and effort in this endeavor. There should be no shortage of participants as there are a large reservoir of HMA members and, as far as topics are concerned, there is even a larger reservoir in this area. It is the hope of this committee that an exchange system with other Educational Networks on the mainland may be formed so that television tapes can be exchanged in order to have some idea of the problem that other communities are having as far as medicine is concerned. HMA has purchased four tapes at a cost of $125.00 per tape and already has taped four particularly interesting programs which are ready for exchange in the future. Communications have already been set up with one particular area, Philadelphia, Pennsylvania, and it is the hope of the committee that the exchange system will go into effect in the near future.

As far as the budget request is concerned, thus far, the visual aids have been provided for by KHET almost entirely. This consists of films for movies, diagrams and charts, which are provided for by their full-time audio-visual technicians at the station, as well as models and sketches. Without the use of visual aids the program has proved to be very dry and, at times, boring. As long as these visual aids are provided, the cost of maintaining the program is negligible when one considers the impact that the program has on each viewer. The committee would like to thank Dr. Theodore Tomita for donating an x-ray view box to the program as a permanent fixture.

The series on the educational network has shown on outlets located on Oahu and Maui. An outlet on Kauai is being studied. It is hoped that this network will soon be extended to all the islands.

In addition to the KTRG-TV program, there was a series called "Doctors at Work" which started in April, 1966, on KHON-TV. These programs were built around a series of films produced by the California Medical Association. They were pretaped and shown on a bi-weekly basis. On September 16, 1966, the station advised that they would no longer carry the series because they were not attracting a large enough audience. However, the station manager said that anytime there was a subject of particular interest, they would allocate public service time. In November this was done for one program on fluoridation.

The HMA no longer has an English-speaking radio program. In January, 1967, KGU advised that the series called "Ask The Doctor" would be discontinued due to their change in format. The Japanese program on KOHO is under the jurisdiction of the Japanese Speakers Bureau Committee.

RECOMMENDATIONS: (1) That the committee continue to concentrate its efforts on the "Medically Speaking . . ." series. (2) That a postcard survey be done to find out if there are any HMA members who are interested in participating who have not yet been called upon. (3) That the policy requiring that priority be given to HMA members be rescinded to permit the committee to select Hawaii physicians who are not members of the Association.

BUDGET:

| | |
|---|---|
| Salary for Gordon Burke @ $30.00 a Program | $1,560.00 |
| Miscellaneous | 100.00 |
| Special Ads | 150.00 |
| Viewer Survey | 100.00 |
| TOTAL | $1,910.00 |

BENJAMIN C. K. TOM, M.D.

*TV-Radio Committee*

A lengthy discussion of this report was heard together with an analysis by its chairman. Your Reference Committee feels that this committee should be commended for its major contribution to public relations. It is recommended that the report and budget be accepted and that recommendations Nos. 2 and 3 be amended as follows:

Recommendation 2: That a post card survey be done to obtain a list of all available and interested HMA members who would desire to participate in the functions of this committee. (3) That the TV-Radio Committee be given the sole authority to select television programs and panelists in accordance with the standing policies of HMA and the ultimate goals of the medical profession. It is recommended that this report and budget and recommendations as amended be accepted.

**ACTION:**

**The Chairman moved adoption of this portion of the report. It was adopted.**

## WOMAN'S AUXILIARY COMMITTEE

There were no formal meetings of this committee. The Auxiliary called the chairman only once for advice. This was regarding a TV program. Permission to participate was given.

When the committee was appointed, it was advised that in the past it had waited until called upon by the Auxiliary to act. The question was posed whether it should show more leadership. There are many Auxiliary projects which escape the notice of the physicians. Some of these overlap the activities of the HMA. This is an area that needs further study and, hopefully, this will be done during the coming year.

RECOMMENDATION: (1) That next year's committee study the desirability of more active liaision and coordination with the Auxiliary.

K. S. TOM, M.D.

*Woman's Auxiliary Committee*

A discussion of the Woman's Auxiliary report was heard and your Reference Committee feels that better liaison with the Woman's Auxiliary should be attained by efforts originating from the HMA. It is recommended that this report and recommendations be accepted and that an additional recommendation be accepted; i.e., that at least one meeting be held with the Woman's Auxiliary to discuss the common goals of each organization.

**ACTION:**

**The Chairman moved adoption of this portion of the report. It was adopted.**

## RESOLUTION NO. 1

Re: HMA Television Programs

WHEREAS, The Hawaii Medical Association has used the medium of television to promote health education among the people of Hawaii since January, 1954; and

WHEREAS, There have been many changes in format; and

WHEREAS, The present series of programs entitled "Medically Speaking . . . " has attained an exceptionally high degree of excellence; and

WHEREAS, This degree of excellence could not have been obtained without the able support and assistance of the people involved in producing these programs; now, therefore be it

*Resolved,* That the Hawaii Medical Association express its gratitude to the men who have contributed so much of their talent and time towards making "Medically Speaking . . . " a success and helping the Hawaii Medical Association attain its goal of providing health education to the broadest possible segment of the population; and be it further

*Resolved,* That this House of Delegates particularly commend Mr. Wendell Jones, the able producer of "Medically Speaking . . . ," whose considerable talent combined with his interest and willingness to give unstintingly of his time has made the Hawaii Medical Association's program both informative and interesting; and be it further

*Resolved,* That this House of Delegates commend the members of the Television and Radio Committee who have acted as coordinators for the programs; Mr. Gordon Burke, the moderator; and Mr. Hugh Lytle, whose faithful assistance over the years has been of such great help; and be it further

*Resolved,* That the Hawaii Medical Association express its appreciation to Mr. Robert Reed, Mr. Clifford Eblen, and Mr. Gordon Tuell of the ETV network for providing the facilities for presenting "Medically Speaking . . ."

Presented by BENJAMIN C. K. TOM, M.D.

*Resolution No. 1*

Your Reference Committee has reviewed the resolution and moves that it be wholeheartedly adopted.

**ACTION:**

**The Chairman moved that the resolution be adopted. It was adopted.**

## RESOLUTION NO. 14

Re: Today's Health Guide

WHEREAS, Pertinent health information is presented in a well-organized, easily read, and clearly illustrated book entitled *Today's Health Guide;* and

WHEREAS, This book could be used as a text for health and family life education in our schools; now, therefore be it

*Resolved,* That the Hawaii Medical Association through its component medical societies encourage wider distribution of *Today's Health Guide* in all hospital and school libraries and in all physicians' reception rooms, and give widespread publicity to the desirability of having every family obtain a copy; and be it further

*Resolved,* That the House of Delegates of the Hawaii Medical Association instruct its Treasurer to appropriate sufficient funds from the 1967-68 budget to enable the Association to purchase one health guide for each high school and accredited college in the State of Hawaii.

Submitted by J. MARK B. SOWERS, M.D.

*Resolution No. 14*

Your Reference Committee recommends adoption of this resolution with the following revision: That the second resolved be deleted.

**ACTION:**

**The Chairman moved that the resolution be adopted. It was adopted.**

## THE WOMAN'S AUXILIARY TO THE HAWAII MEDICAL ASSOCIATION

In keeping with the aloha spirit, we of the Hawaii Medical Auxiliary have sought to show our love through service. It has been a wonderful year, full of adventure and new experience with many opportunities for personal growth and self-expression.

Although our State is only seven years old, our Auxiliary was organized eighteen years ago. From an original nucleus of forty community-minded women, we have expanded to a total of 619 active members in three counties. We have 100% team membership, and are grateful to our doctor husbands for their support.

In June, three of us attended the convention in Chicago, and still remember the joy and enthusiasm that radiated from the other delegates as well as from the national officers and chairmen. The Fall Conference was also a stimulating experience for our President-elect, Mrs. Charles Yamashiro, and me. Eight of us attended the original workshop in Denver and reported our new knowledge, in addition to sharing our inspiration, at our State conference in November. We are grateful to the AMA and the national Auxiliary for helping to make these trips possible.

AMA-ERF continued to be a very popular project.

Due largely to the tremendous success of the dinner and silent auction sponsored by Honolulu County, we were able to contribute $3,370.78, an increase of $1,052.13 over last year. The sale of candy, Christmas cards, greeting cards, and note paper in addition to In Memoriam donations produced a steady income. Kauai County received the award for the highest per capita donation.

Community Service has also been emphasized this year. Honolulu County invited seventy presidents of civic and service clubs and the wives of the interns and residents to attend their annual guest day meeting. The subject of the meeting was "Allergy in Hawaii." A question-and-answer period followed a discussion by a panel of doctors. The Honolulu Auxiliary worked closely with a number of organizations to achieve maximum effectiveness. They helped the Department of Health in the detection of diabetes and glaucoma and the Hawaii Heart Association in their "Heart Sunday" campaign. They worked with the Oahu Council of Churches to plan a general membership meeting to which they invited the clergy, their wives, and nuns to see a movie and hear a panel discussion about cooperation between medicine and religion. An Auxiliary member is on the board of the Planned Parenthood Council, and through them is working on the possibility of introducing venereal disease education into public and private schools. Another Auxiliary member is on the board of the Hawaii Cancer Society in an educational capacity. Members also distribute packets of "Medical Messages of the Month" leaflets to doctors' offices to be included with their statements. These messages are published by the Hawaii Medical Association.

The Health Careers chairman supplied copies of *Horizons Unlimited* to all high schools and intermediate schools. This committee actively participated in the Medical Careers Day program sponsored by the HMA on February 22, 1967. One hundred and twenty interested high school students had breakfast with the doctors, toured hospitals, examined equipment, and listened to a talk on the curriculum of the University of Hawaii Medical School. Invitations were sent to interested high school and college students, teachers, and counselors to attend Nurses Careers Day to promote an interest in nursing. The committee worked closely with the Hawaii League for Nursing to formulate plans for this event.

*In Memoriam—Doctors of Hawaii* continues to grow. Fourteen new biographies were added for a grand total of 411. Seven biographies were revised to include new data. Eighteen new photographs were acquired during the year, making a total of 215.

In international health activities, Honolulu County has done a tremendous job. Our State is favorably located to obtain transportation for supplies to other islands in the Pacific and to the countries of Asia. Forty-six large boxes of clothing and medicine were sent to Samoa, and 400 pounds of medicines were delivered to the Trust Territories. Through Operation Handelasp, 1,200 bottles of I.V. solutions donated by the Baxter Company, were sent to Hong Kong, which also received 600 pounds of medicine from doctors on Oahu. The Air Force helped us deliver half a ton of I.V. solutions to Saigon Sanitarium and Hospital. Four large boxes of clothing were sent to Korea, and 400 pounds of medicine to the Philippines.

The Mental Health Committee sent letters to PTA program planning chairmen on all the islands to encourage their use of the Mental Health Packet. In February, the State chairman attended the Mental Health Association workshop on changes and revisions of mental health laws pertaining to commitment as well as responsibility of criminals if mentally ill. In cooperation with Honolulu County, we purchased the film "Cry for Help" which is used regularly at the University of Hawaii and by the police department in their officer training program. Honolulu Auxiliary members donated over 200 gift-wrapped Christmas presents for the retarded children and adults at Waimano Home.

Members of the Safety Committee maintained a safety booth at the annual Hawaii Congress of Parents and Teachers Association. Approximately 500 packets containing program ideas were distributed. Bibliographies contained twenty suggestions on topics such as poison prevention, safety at home, and traffic safety. The Auxiliary was represented at a two-day safety symposium sponsored by the U.S. Air Force. Mrs. Charles Yamashiro gave a speech and showed a film entitled "Family Off Guard." A member of the Auxiliary helped to plan the Oahu Traffic Safety Seminar held recently at the Princess Kaiulani Hotel. Honolulu County also provided safety messages for local radio station KGMB to be used in thirty-second slots as a public service. The Junior League helped distribute 30,000 leaflets on first aid and poisons to the schools. This project was co-sponsored by the Auxiliary and Meadow Gold Dairies. During Poison Prevention Week, two of our members discussed poisoning on the educational television station and on the Aliee Jackson Show. They also supplied traffic safety hints to radio and TV stations. Our poison prevention slides were copied by the Junior League, and are frequently shown by a number of organizations.

Many treasures have been added to my museum of memories, and I am grateful to all the officers, chairman, and members for making this such an enjoyable and successful year.

Mahalo and aloha!

DOROTHY HARRISON (MRS. JAMES G.)

*Woman's Auxiliary Report*

Your Reference Committee reviewed the Woman's Auxiliary Report and commends the Auxiliary for its great efforts throughout the past year. It is recommended that this report be accepted.

**ACTION:**
**The Chairman moved adoption of this portion of the report. It was adopted.**

## PUBLIC RELATIONS COUNSEL

In January, 1950, the Hawaii Medical Association began an intensive program of public education that culminated in weekly TV and radio programs, issuance of weekly press releases dealing with medical and health matters, organization of a speakers bureau, and assorted other projects requiring participation by physicians to insure their success. The program is constantly being modified by the committees responsible for the various aspects of the continuing program. Each committee chairman has filed a separate report.

Since inception of the program, no less than 300 physicians have taken part in one phase alone, that of the educational television series. Others have written widely for the press, spoken on medical subjects before clubs and associations and by radio, and have taken part in the educational effort in numerous other ways. In doing so, many have lost groundless fears of ethical publicity that in the past worked against public understanding of the profession.

Such general participation has placed the Hawaii Medical Association—to my personal knowledge—in the top 10 per cent of all medical groups in the nation so far as the impact of its educational campaign is concerned.

Other associations are larger, have more outlets and more volume. This Association has drive, general participation, committee leadership that can only be called dedicated—and something called elan.

And now, how do the doctors stand with their own patients? That is a field meriting study. And it is a field in which most laymen feel qualified—and are qualified—to comment. Most important, it must be remembered that public relations is an ongoing activity—it is nodt successful when used to put out fires.

HUGH W. LYTLE

*Public Relations Counsel*

Your Reference Committee revicwed the report and recommends the approval of this report.

**ACTION:**

**The Chairman moved adoption of this portion of the report. It was adopted.**

## HAWAII MEDICAL JOURNAL

A steady five-year decline in advertising pages, from an average 53 per issue to an average 38, has been almost completely erased in this past year; the average number of pages of advertising in the past six issues was 50, and the increase has ranged from 10 to 25 per cent in every one of the six issues, to a high of 73 in the March-April one. It seems to be a national phenomenon, though our switch a year ago from the State Medical Journal Advertising Bureau to the State Journals West organization may deserve at least some share of the credit for it. In other respects, this new relationship has proved fairly satisfactory so far, though there are a few problems still to be solved.

No changes in format, layout, personnel, or policy were made during the year, and only one independent editorial position was taken, reversing an earlier one: we strongly supported the Aloha United Fund on the ground that it was obviously going to be highly successful and money is more important to health agencies than motivation is.

Book reviews, under Dr. Winfred Lee's editorship, totalled 66, plus 44 capsule comments; 110 books for the Hawaii Medical Library as the gift of the Hawaii Medical Association.

The only deviation from routine during the year was the preparation by Miss McCaslin and Mr. Lytle, in strictest secrecy, of a special issue honoring the Editor on the 25th anniversary of the JOURNAL. It was a great honor, indeed, and deeply appreciated!

RECOMMENDATIONS: (1) An eminently suitable person has been found for the job of Assistant Editor which was proposed in our 1966 report: Mrs. Jean Booher, who is also Assistant Editor of another medical periodical with which I am involved. I have had a year to observe her work, and it is the epitome of competence in every respect; she is thoroughly familiar with medical terminology as well as with the construction of lucid English prose, and also completely conversant with typography, layout, and printing technology. I doubt that there are a dozen persons in the country who can beat or even equal her at editing medical manuscripts and preparing them for the printer. She is willing to accept the position at the suggested salary, on a simple contractual basis. I feel that this is a necessity. Although her present residence is in Fort Lauderdale, Florida, the modest additional expenditure of postage required by this brings us as close together as necessary, with less loss of time than is regularly incurred here in Honolulu through simple procrastination. (2) This is the only recommendation made in addition to the usual annual recommendation that you authorize the continued publication of the HAWAII MEDICAL JOURNAL on the same basis as in the past.

HARRY L. ARNOLD, JR., M.D.

*Editor's Report*

Your Reference Committee discussed at length this report in the presence of the Editor, Dr. Arnold. It recommends the acceptance of this report and its two recommendations to enhance the quality of this growing JOURNAL.

**ACTION:**

**The Chairman moved adoption of this portion of the report. It was adopted.**

## RESOLUTION NO. 22

Re: Woman's Auxiliary

WHEREAS, The Woman's Auxiliary to the Hawaii Medical Association has worked diligently to augment the community service functions of the medical profession, thus improving the public image of the profession; and

WHEREAS, The Auxiliary has contributed materially to the success of the AMA-ERF program; and

WHEREAS, The Auxiliary has worked successfully with voluntary health organizations in Hawaii for the betterment of community understanding; and

WHEREAS, The Auxiliary has honored members of the Medical Society posthumously; and

WHEREAS, The Auxiliary in every way has reflected credit to the image of the medical profession in Hawaii; now, therefore be it

*Resolved*, That the Hawaii Medical Association express its gratitude to the Woman's Auxiliary; and further be it,

*Resolved*, That the Woman's Auxiliary be complimented on the high quality of performance in its projects during the past year.

Submitted by HONOLULU COUNTY MEDICAL SOCIETY

*Resolution No. 22*

Your Reference Committee reviewed this resolution and moves its adoption.

**ACTION:**

**The Chairman moved that the resolution be adopted. It was adopted.**

## RESOLUTION NO. 23

Re: Public Relations Counsel

WHEREAS, In 1960 the physicians of Hawaii agreed that there was a need for continuing, professional public relations in order to develop a better understanding with the lay people of the medical profession; and

WHEREAS, After an ad hoc committee had searched widely for someone who could offer a positive action program in keeping with the dignity of the medical profession, Mr. Hugh Winston Lytle was selected for this position; and

WHEREAS, Although Mr. Lytle agreed to serve only on a part-time basis, he has over the years been on call, night and day and has given unstintingly of his time and ability week in and week out, year in and year out; and

WHEREAS, During the years Mr. Lytle has been associated with the Hawaii Medical Association there has been increasingly satisfactory rapport between the physicians and the various news media, with an invaluable public education program which has included a newspaper column and a successful weekly TV show; and

WHEREAS, Mr. Lytle has made himself and his valuable advice and services available to the Association staff, the physician members of the Association, and their wives, and this advice and service have been of inestimable value to the Hawaii Medical Association; and

WHEREAS, Mr. Lytle has brought to the physicians of Hawaii the benefit of his knowledge, his judgment, his rapport with the lay public, his writing skill, and his wit; and

WHEREAS, Although a present status of good public relations has been attained, it could have been neither achieved nor maintained without the assistance of Mr. Lytle who has taught us that public relations is an ongoing project which requires constant nurturing; now therefore be it

*Resolved*, That the House of Delegates of the Hawaii Medical Association take this means of expressing its gratitude to Mr. Hugh Winston Lytle for the work he has done on behalf of the Association and its hope that the beneficial relationship may long continue.

Submitted by the HONOLULU COUNTY MEDICAL SOCIETY

*Resolution No. 23*

Your Reference Committee reviewed this resolution and moved its adoption unanimously.

**ACTION:**

**The Chairman moved that the resolution be adopted. It was adopted.**

**The Chairman moved the adoption of the report as a whole.**

**It was voted to accept the report as a whole.**

Your Reference Committee Chairman wishes to express his appreciation to the committee members for their help and to the President for referring noncontroversial matters to the committee.

## INSURANCE AND MEDICAL SERVICE

Mr. President and Members of the House of Delegates:

Your Reference Committee met before an audience of approximately 25 physicians and guests and received testimony on the various resolutions and reports submitted to the Committee for consideration and recommendation. Having heard the discussion of the witnesses and having given careful consideration to all the testimony presented to it, your Reference Committee is pleased to make the following report:

### INDIGENT MEDICAL CARE COMMITTEE

The committee met as a whole on two occasions during the year and may meet a third time subsequent to the writing of this report.

The committee as a whole did not meet until late in the year but the chairman and other members of the committee did meet as representatives of the Indigent Medical Care Committee with other committees involved in various aspects of care for the medically indigent. Thus, this committee has been involved with the Hospital Committee and the Medical Care Plans & Fees Committee, especially in discussion relating to indigents formerly under the government physicians' program. The committee was involved and aware of the negotiations which were arrived at in phasing out this program. The chairman and two other members of this committee have taken part in discussion of the ad hoc committee concerning medical education in the hospitals and its relation to the changing picture of payment for care of the medically indigent patients involved in the teaching program.

The tremendous potential effect that Title XIX can have in Hawaii and throughout the nation has become increasingly evident over the past year. A report of the status of Title XIX in Hawaii was given by the chairman of this committee at the Commission on Medical Services meeting on February 20, 1967. This information was obtained from Mr. Millar of DSS and differed somewhat from that given later by Mr. Yoshimura of DSS. Briefly, Mr. Millar stated that the Title XIX provisions have been entirely met in Hawaii except for one problem of house visits in Honolulu. In other words, as the program stands the indigent and medically indigent of all ages are covered in Hawaii. This includes the medically indigent in the 21-65 year group, coverage of whom was not required by law until 1975. Thus, it was felt Hawaii had one of the most comprehensive programs in the nation as far as scope of services is concerned. The key factor here, however, is the eligibility or income level by which one is determined to be medically indigent. At that time the level was $3,000 for a family of four and $1,440 for a single person. This was originally thought to cover six to seven per cent of the population, but it was found later to cover around 11% of the population, roughly 37,000 persons. Thus, potentially a great portion of the persons in the State can become medically indigent by merely liberalizing the eligibility level. The plans for raising the present income levels for eligibility during the current legislative session were discussed at a meeting held on April 11, 1967. Mr. Robert Millar and Mr. Ed Yoshimura of DSS were present. They stated the present budget for medical care which they have requested is 9 million dollars. This is up from the current budget (6.4 million) by 2.5 million dollars.

The reasons for this increase in budget were threefold: (1) The yearly increase in medical costs. (2) Appropriation of more money to cover items not now covered such as family planning, provision for dentures, preventive health services, private duty nursing in hospital, etc. (3) The third reason involves liberalization of eligibility standards. Included in the budget is a 20% across-the-board increase in the income level for eligibility. This means the ceiling for a family of four would go up to $3,600 (from $3,000) and for a single person it would be increased to $1,728 per year (from $1,440), and so forth. It was brought out that this 20% increase would raise the per cent of population covered under indigent and medically indigent program to 18% of the total population. The status of these proposals by DSS will not be known until the present session of the Legislature is finished. We will be brought up to date at that time. One other method by which DSS wishes to liberalize the eligibility of indigents is to allow them to have increased liquid assets, above their income, amounting to three months' living costs.

Another important area of discussion at this meeting concerned the different interpretations of Title XIX and the section of this law which requires that inhospital physician services under Title XIX must be paid for on and after July 1, 1967. This is the interpretation of Dr. Phillip Lee of HEW. The Bureau of Family Services, according to DSS, has a different interpretation. This point has been checked out several times by James H. Fleming, Secretary of the Committee on Welfare Services of the AMA, who advised that the Bureau of Family Services had provided him with information.

Mr. Fleming goes on to say "the distinction between 'payment for' and 'provision of' services is not a real, but an apparent one, in public assistance usage. The point is simply that the state agency cannot claim to be providing a service unless it is either physically providing it (in its own facilities and/or by use of its own staff) or paying for it. It is irrelevant to the legal requirements of Title XIX whether or not physicians are actually providing the care to Title XIX recipients; if Title XIX is not 'paying' for the physicians' services, then Title XIX is not 'providing' them and, as of July 1, 1967, it will not be meeting the legal requirements of the act."

With the above interpretation from Dr. Lee of HEW as a basis of our understanding of the law, Mr. Millar and Mr. Yoshimura were asked if they agreed with this interpretation. Their answer was a definite no. Mr. Millar stated that they were sorry that we had not seen fit to accept their interpretation of the law, which is that they provide these services as they have in the past with no changes. He said we had not asked for an interpretation from the right HEW Division, the Bureau of Family Services.

As to the point that they will not be providing these services unless they are paying for them, Mr. Millar stated that the law does not say that. He said that the above interpretation was given by a man in HEW whom he didn't think should have given this interpretation because he is not part of the Bureau of Family Services whose program this is. Thus, Mr. Millar stated that they anticipated no change in urban Honolulu as of July 1, 1967, except for payment of house calls which must be included by July 1.

Mr. Yoshimura further defended their "interpretation" of this part of the law as follows: "if a person is found to be eligible under Title XIX, we relate these individuals to the public assistance programs Title IV and Title XVI of the Social Security Act. Under Title IV and Title XVI of the Social Security Act, there is a definite requirement that whenever medical care or any resources are made available, these must be used first. Thus, in the hospitals where there is a medical education program where the hospital has offered staff services at no cost, these are considered resources under the interpretation of utilization of resources under Title IV and Title XVI of the Social Security Act, and thus we are justified in using staff services."

Many other important factors were discussed at the April 11, 1967, meeting and I refer you to the minutes of that meeting for their perusal.

The other meeting of this committee as a whole was held on April 4, 1967, at which time two main items were discussed: (A) Implementation of Public Law 89-749, and (B) Title V of the Social Security Act amendments.

(A) Dr. Wilbur Lummis and Dr. De Jesus presented a well-formulated summary of this law. Briefly, the law was created in an effort to condense fragmentary grants into one lump sum for public health planning and services. The law is comprehensive and involves more than purely health problems. The total picture of this bill can be gotten from a summary passed out by Dr. Lummis.

Four steps are necessary to put the program into effect: (1) The government has directed the state to appoint a single state agency as the administrator. Governor Burns has designated the Department of Health as the agent. (2) A "plan for planning" must be submitted for which the Department of Health will receive a certain amount of money. (3) An advisory council consisting of at least 50% of the consumer public must be appointed. (4) The department must come up with the ultimate of a state comprehensive health plan. The date for the implementation of the plan is the end of 1967.

It was felt at this meeting that knowledgeable physicians in the various areas of health services should work together in helping to implement and direct the various aspects of this law.

(B) Title V.—This was discussed by Drs. Sia and Childs and involves funds provided by the Federal government on a 3-to-1 matching basis to care for children in poverty indigent areas. This program is similar to the one now in effect involving care of maternal health with clinics in Nanakuli, Waimanalo, and other areas. Over the past few months this program has been expanded more intensively jointly by Children's Hospital, Department of Health, the University, and the Children's Bureau. Basically the service is directed at the community level to the indigent population. The clinics would be serviced by private physicians with coordination of the Health Department and Children's Hospital physicians. It is not the intent to put the clinics in competition with private practitioners or hospitals but in indigent care it must be realized that there are specific areas that need the total care that such a clinic can provide. It was pointed out that these programs were meant to be temporary until Title XIX can be fully implemented and thus will cover these areas.

RECOMMENDATIONS: (1) This committee should be kept up to date on the latest developments in Title XIX and its full implementation by frequent meetings with DSS and also be informed of any other laws involving care of Hawaii's indigent population. (2) This committee should be involved in all discussions regarding indigent medical care by other committees of the HMA (i.e., Medical Care Plan & Fees Committee, Hospital Committee, etc.) so that the total picture of indigent medical care will be coordinated through this committee. (3) This committee recommends that the HMA support the interpretation as given by Dr. Phillip Lee of HEW that under Title XIX of the Social Security Act inhospital physician services must be paid for on and after July 1, 1967, and that if the DSS is not paying for these services or providing for them through their own facilities as of July 1, 1967, then they are not meeting the legal requirements of the law.

PATRICK J. WALSH, M.D.

*Indigent Medical Care Committee*

Your Reference Committee first considered the report of the Indigent Medical Care Committee. A full and complete discussion of the subject was had. Your Reference Committee recommends deletion of Recommendation No. 3 in view of information received from a communication from HEW dated March 9, 1967, which reads in part as follows: "A State must do more than merely provide for physicians' services (in its plan); it must arrange for the delivery of services. If, however, the provider of services is willing to render such service without charge, this is not necessarily contrary to the provisions of Title XIX—the single State agency is merely utilizing an available resource in implementing its plan."

Your Reference Committee further recommends that the HMA advocate that under Title XIX of the PL 89-97 the inhospital and outpatient physicians' services should be paid for on a reasonable fee-for-service basis after July 1, 1967.

Your Reference Committee recommends that recommendations Nos. 1 and 2 be approved.

**ACTION:**

**The Chairman moved adoption of this portion of the report. It was adopted.**

## FEDERAL MEDICAL SERVICES COMMITTEE

The committee has met almost every other month to review claims for (1) eligibility, (2) fee determination, (3) procedures requiring reports, or (4) claims needing adjudication for other reasons. A few of the common procedures which were previously unlisted have now been added to the schedule by amendment and no longer have to be brought up before this committee for review.

The title of ODMC (Office for Dependent Medical Care) has been changed just recently to OCHAMPUS (Office of Civilian Health and Medical Program for Uniformed Services). OCHAMPUS has increased civilian health benefits this past year as follows: Part A: Outpatient care for eligible spouses and children of active duty personnel—effective 1 October 1966. Part B: Inpatient and outpatient care for eligible dependents and retirees—effective 1 January 1967. Part C: Handicapped program for eligible spouses and children of active duty personnel—effective 1 January 1967.

A request was made of OCHAMPUS for sufficient copies of the contract to enable us to make a distribution to the members for their review. A request was also made for blank copies of the schedule of allowances, a part of the contract, in order that the provisions of this supplement which regulate the fees could be reviewed. Our requests have not yet been filled. In view of this, a request has been made for a three-month extension of the current contract. The committee will meet with HMA's Negotiating Committee before they approach OCHAMPUS. In the meantime, direction from the House of Delegates is requested for establishing terms of the new contract.

The fiscal agent, HMSA, circulated details of the increased benefits as outlined in the contract. This information was not easily interpreted by the physicians and so a supplemental bulletin was drawn up by the HMA staff. This was submitted to OCHAMPUS for approval and after several drafts, a compromise was agreed upon. This draft was sent to HMSA on March 22 with a request that it be disseminated. To date no answer has been received, and no bulletin has been sent.*

Requests for information have been directed to the AMA and other state medical associations. Both Illinois and Florida were instructed by their House of Delegates not to sign a contract with ODMC unless it was on the basis of usual-and-customary fees. ODMC would not agree to this approach of reimbursement and so neither of these states has a contract with the government at this time.

On January 26 the AMA advised as follows: "Now that we have a clearcut statement from ODMC that direct billing can be used for these patients, and have disseminated this information to the state societies, I feel that the possibility of more adequate fees is a much closer one." Col. Hayes of ODMC subsequently advised by telephone that this is not the case. A participating physician may not bill direct and must submit a claim form to the fiscal agent which states that he will accept the fees allowed as payment in full. The HMA, under the terms of the contract, must encourage its members to participate.

With reference to the contract with the Veterans Administration, no modifications have been made nor are any contemplated.

* Subsequently the bulletin was sent out.

RECOMMENDATIONS: (1) That the OCHAMPUS contract for the year beginning July 1, 1967, be signed when it incorporates the following provisions: (a) that in addition to the current conversion factor of 5.00, the physician be reimbursed for the 4% General Excise tax if it is his custom to show this tax on all his bills; (b) that the schedule of allowances be distributed to all physicians with the allowable amounts inserted; (c) that the physicians who dispense according to the AMA Principles of Medical Ethics be reimbursed for the acquisition cost plus handling charges; (d) that the HMA be permitted to advise physicians of the disadvantages as well as the advantages of participating in the program; (e) that OCHAMPUS agree that upon the expiration of the contract to be signed, the RVS format be adopted; and (f) that the President be authorized to sign the contract on recommendation of the Commission on Medical Services.

WILLIAM W. L. DANG, M.D.

*Federal Medical Services Committee*

Your Reference Committee next considered the report of the Federal Medical Services Committee. A full and complete discussion of the subject was had. Your Committee recommends approval of all the committee's recommendations.

**ACTION:**

**The Chairman moved adoption of this portion of the report. It was adopted.**

## FEE SURVEY COMMITTEE

This committee met at regular intervals to determine what program to follow. It was decided that a second survey is needed and the methods for accomplishing this have been developed.

Contact with Mr. Harry Victor was made and an estimate received on the cost for the statistical services required in conducting the second survey. His recommendations to revise the questionnaire are being followed and the committee is meeting with physicians from each of the specialties to be certain that a representative number of procedures are included. It is our goal to have this material ready for mailing by September and the results tabulated before the end of the year. If it is deemed necessary, a revision of the 1965 RVS should be ready for publication early in 1968.

Less than 250 of the 1,250 copies originally printed are now on hand. Sales to date have amounted to $758.50. The policy set forth has been that members were given one copy free provided the request was received in the HMA offices prior to October 1, 1965. Subsequent to that date members have been charged $1.50 a copy. Additional copies to members are sold to them at the $1.50 rate. All nonmembers are charged $5.00 a copy. The Council voted to permit sale of the RVS to State agencies that employ member physicians at the member price of $1.50. This cost was used in billing both the Department of Social Services and the Division of Vocational Rehabilitation.

RECOMMENDATIONS: (1) That insofar as possible the members of this committee be reappointed by the President for 1967-68 in order to provide continuity in the study. (2) That the House of Delegates confirm the appointment of Mr. Harry Victor as the statistician to conduct the second survey. (3) That the method for conducting the second survey be the same as that employed in 1963. (4) That the questionnaire be revised to contain more procedures. (5) That the House of Delegates authorize printing of a revision of the 1965 RVS if the Fee Survey Committee deems this necessary and the Medical Services Commission concurs. (6) That the House of Delegates consider authorizing development of positive methods for educating physicians and their office staffs in the use of RVS, Workmen's Compensation schedules, Foundations for Medical Care benefits, etc. (7) That the definition of this committee's activities for inclusion in the Bylaws reads as follows: "Fee Survey Committee shall be responsible for the study, development, modification, and printing of all fee schedules, including the relative value study. Appointments to this committee shall be for a period of three years and shall include representatives from at least eight specialties."

BUDGET REQUEST:

| | |
|---|---|
| First mailings | $ 30.00 |
| Printing of questionnaire | 250.00 |
| Mailing of questionnaire | 50.00 |
| Return postage on questionnaire | 80.00 |
| Reminder mailings | 30.00 |
| Data processing | 1,720.00 |
| Spot checks (100 @ $10.00) | 1,000.00 |
| Preparation for printing | 300.00 |
| Printing of revised RVS | 1,500.00 |
| TOTAL | $4,960.00 |

FREDERICK B. WARSHAUER, M.D.

*Fee Survey Committee*

Your Reference Committee next considered the report of the Fee Survey Committee. A full and complete discussion of the subject was had.

Your Reference Committee recommends approval of all four recommendations and the budget request.

**ACTION:**

**The Chairman moved adoption of this portion of the report. It was adopted.**

## MEDICAL CARE PLANS & FEES COMMITTEE

The committee had several meetings during the 1966-67 year, all of which were well attended by the members. The material deliberated upon was confined primarily to the area of Title XVIII and Title XIX of PL 89-97 (Medicare) and the provision of free choice of physician and hospital for the indigent and medically indigent in rural Oahu and on the neighbor islands.

The issues directly related to the Department of Social Services were as follows:

(1) Free choice of physician for Title XIX patients in rural Oahu and neighbor islands. Impetus for this departure from the former method of utilizing government physicians to provide medical services stemmed from HB 199, House Draft #1, Senate Draft #1, Conference Draft #1, of the 1966 Legislature which stated, in part, "Your committee recognizes certain merits of resorting to the use of fee for service physicians to provide medical care to the indigent and medically indigent on the neighboring islands and rural Oahu. We have accordingly provided the Department of Social Services the flexibility to phase out the present system of employing government physicians if and when deemed feasible. It is requested that the Department of Social Services carefully assess both methods and pursue the necessary course of action within the means provided for in the budget. A report of this matter is expected before the convening of the next general session."

After lengthy discussions, this committee agreed to support the change in concept as proposed by the DSS—Free choice of physician for all Title XIX patients in rural Oahu and the neighbor islands on a fee-for-service basis with the fee schedule based on the 1965 Hawaii RVS using a conversion factor of 5.00. Because of limited DSS funds for the remainder of the present fiscal year, the committee agreed to provide a subsidy of 20% for the surgical section and 30% for the medical section. This fee schedule to operate only from January 1, 1967, to June 30, 1967, at which time the subsidies to the State of Hawaii are to cease and the physicians servicing this program are to be reimbursed at the full 5.00 factor for all sections.

(2) The problem of providing and paying for drugs for the Title XIX patients in rural Oahu and on the

neighbor islands received a great deal of attention from this committee and the Pharmacy Committee. Both committees are on record as not supporting the DSS-proposed formulary or utilization of generic drug names. It was apparent that the DSS did not do an adequate amount of research in developing the formulary. Some of the drugs included in it are outdated. There is no assurance that this method will hold the line on drug costs. The action in developing the formulary was unilateral on the part of the DSS and, in many instances, contrary to the good and usual practice of medicine. If continued, it will adversely affect the quality of medical care now existing in Hawaii.

(3) The committee does not approve of the claim form which DSS wants the doctors to use for their clients. One reason for this is that the form is dissimilar to the Title XVIII form. In addition, there are important omissions and areas of confusion. Also it adds additional and unnecessary work for the doctors.

(4) Considerable time was spent in the past year in this committee and in the Hospital Committee studying and discussing the fiscal and economic problems of hospital-based physicians as private practitioners of medicine and purveyors of medical service to DSS clients. It is gratifying to see that there is greater unanimity of thought and direction being generated independently by these specialists. However, there is still significant variation from specialty to specialty, hospital to hospital, county to county, and doctor to doctor. This keeps the solution of that tantalizing and difficult problem just out of reach and all concerned continually off balance. This committee believes that knowledgeable representatives from the involved specialty groups, hospital representatives, and DSS representatives must get together on common ground to resolve this inequitable, irregular, and unacceptable situation.

The Department of Health's health services were given much thought. Both this committee and the Negotiating Committee met with representatives from the Department of Health in an attempt to standardize and develop an equitable reimbursement program for the medical services provided by private physicians to patients whose care is supported by the various State agencies under the jurisdiction of the Department of Health. At the present time, the discussion has centered around the Hawaii 1965 RVS and a conversion factor of 5.00. This rate if reimbursement is being requested by the Department of Health in its current budget for services now covered on a fee-for-service basis. The Department has not requested funds which would permit them to convert their hourly clinic rates to fee-for-service type reimbursement.

The Chronic Illness and Aging Committee referred to this committee the method of assignment of benefits which is being used at a government hospital. This matter has not yet been reviewed. Allegedly, the physicians who care for the patients at this unit who are eligible for Title XVIII benefits have their billing done by the City and County at the rate of $1.00 a visit and then assign the money they receive from Aetna back to the government.

Several problems in the area of plantations and the practice of medicine were presented to this committee for perusal. (1) The payment of Title XVIII, Part B, fees and the manner in which this conflicts with existing doctor-plantation contracts present a most difficult situation. The corporate practice of medicine by plantations is believed to be illegal under the Hawaiian statutes. There is still a great deal of study and work to be done in this area before these problems can be resolved. However, the fiscal intermediary for Part B (Aetna) has been advised by HEW that payments under Title XVIII must be paid either to the physician or the patient except when the organization qualifies as a prepayment plan, which at present the plantations do not.

RECOMMENDATIONS: In order to resolve some of the problems and keep the economics and practice of medicine on a sound and equitable level and especially to keep out of third-party contracts from the practice of medicine, the following recommendations are made for adoption as HMA policy:

(1) Contract medicine in Hawaii is acceptable only if the parties involved agree to operate within the bounds of the principles of medical ethics as interpreted by the AMA Judicial Council: A contract is unfair or unethical (A) when the compensation received is inadequate based on the usual fees paid for the same service and class of people in the same community; (B) when the compensation is so low as to make it impossible for competent service to be rendered; (C) when there is underbidding by physicians in order to secure the contract; (D) when a reasonable degree of free choice of physicians is denied those cared for in a community where other competent physicians are readily available; (E) when there is solicitation of patients directly or indirectly.

(2) That the HMA insist that the State of Hawaii budget necessary funds in order that private physicians may be reimbursed in a fair and equitable manner for services rendered to those who are dependent on the State for payment of their medical care, and that this project be given top priority by next year's Legislative Committee.

(3) That the HMA, in order that no citizen of this State may feel he is getting second-class medical care, advise the DSS to provide for all Title XIX patients throughout the State the same free choice of physician and medical facility regardless of place of residence.

(4) That the HMA caution its members that they not be duped into allowing third-party regulation of medicine or hospital practice of medicine to take place under the guise of "continuing medical education for practicing physicians and house staff," and that a panel of physicians formed in a hospital to provide this type of service is irregular and unacceptable.

(5) That the HMA inform the appropriate body in the State government of the inequities and false security in the proposed use of a formulary with generic names of drugs for patients whose medical care is paid for from government funds.

(6) That the HMA notify the Hawaii Hospital Association that it supports the principle of individual billing and collecting of fees by hospital-based physicians, not only for their private patients but also for those whose bills are paid for from government funds. Further, that the HMA oppose the provision proposed in HR 5710 that would establish a Part C in the Medicare law by amending PL 89-97 to change the method of paying hospital-based physicians.

(7) That the HMA look into the billing practices used for Title XVIII patients at government hospitals.

GEORGE H. MILLS, M.D.

*Medical Care Plans and Fees Committee*

Your Reference Committee next considered the report of the Medical Care Plans and Fees Committee. A full and complete discussion of the subject was had.

Your Reference Committee recommends that all seven recommendations be approved.

**ACTION:**

**The Chairman moved adoption of this portion of the report. It was adopted.**

## NEGOTIATING COMMITTEE

This committee works under the jurisdiction of the Commission on Medical Services and has as its chief function the negotiation of fee schedules and related matters dealing with third-party organizations in their involvement with the HMA or its members.

During the past year the committee has deliberated on the following:

(1) After a number of meetings with the DSS, the committee recommended and the Council approved of the proposal that the DSS be granted a subsidy in the amount of 30% on the medical and 20% on the surgical sections of the Hawaii 1965 RVS converted at 5.00 for

the period ending June 30, 1967. The DSS was instructed by the Legislature to investigate the feasibility of permitting its clients in rural Oahu and the neighbor islands to have free choice of physician. The committee concurred with this philosophy and submitted its proposal in order to permit the DSS to follow this concept and remain within its allotted budget. The initiation of this program depended upon actuarial studies made to determine what period the funds would cover. The HMA was not notified of the DSS's intention to initiate the program until just a few days before it went into effect nor was the HMA given an opportunity to review the regulations governing the program. When the rumor that the DSS planned to establish a formulary was noted, this matter was turned over to the Pharmacy Committee whose objections and deliberations will be covered in its report.

The HMA is of the opinion that in order to obtain Federal funds for its Title XIX program, the DSS must as of July 1, 1967, pay for the physicians' services "whether furnished in the office, the patient's home, a hospital, or a skilled nursing home or elsewhere." (PL 89-97, Sec. 1902.a.13, Sec. 1905.a.5.) The DSS feels it only has to provide these services and is not required to pay for them, and has not provided for this contingency in its 1967-68 budget. Several attempts have been made to meet with Mr. Among and discuss this and other matters but, up to the time this report was prepared, a meeting had not been scheduled.

(2) The Department of Health was requested to revise its fee schedule which is currently on the basis of the Hawaii 1965 RVS converted at 3.75 for surgery, 4.00 for medicine, and 4.50 for pathology and radiology, to 5.00 for all sections. The Department's 1967-68 budget request is on the basis of 5.00 but at the time this report was prepared it was not known whether the Legislature will approve this request. In addition, the committee requested that the private physicians serving in the Department of Health clinics and conferences be compensated on a fee-for-service basis rather than on the hourly rate now in effect. Dr. Quisenberry advised that this would involve a larger budget and he did not feel he could make the request for the coming fiscal year. In the meantime, a poll was made of the physicians who serve in these clinics to see if they wanted the HMA to pursue this matter further and to determine if our stand was one of which they approved. Forty cards were returned and only five of these indicated the physician was satisfied with the present set-up. Thirty-three asked that the HMA continue to negotiate with the Department of Health. Thirty-one indicated they would continue to provide services.

(3) The problem of the plantation physician contracts was brought to the Council and referred to this committee. This matter came to a head with the advent of Medicare and the plantations' requirement that the physicians, in most instances, assign the benefits collected from Aetna over to the plantation. A number of arrangements have been proposed by the plantations, none of which offers the retiree a choice of physician. The committee prepared a statement of policy in which free choice of physician and hospital was reemphasized, disposition of professional income was left to the physician, and a change in relationship between the physician and plantation was recognized. This was sent to the president of the Hawaii Industrial Medicine Society, Dr. Edwin Willett, with the suggestion that his members be polled to determine if the HMA's position met with their approval and whether these doctors did in fact want the HMA to negotiate with the plantations in their behalf. Legal counsel has been sought in this matter on several occasions and meetings have been held with Aetna representatives. Aetna has received the HEW ruling that they cannot pay the plantations direct unless the plantations qualify as prepayment plans. One of the requirements for such a plan is that each facility have at least three different medical specialties represented on its physician staff. The plantations, it is believed, do not wish to become prepayment plans. Dr. Willett advised that due to lack of help he could not send out a questionnaire and asked the HMA to do this for him. Sixteen questionnaires were returned. Three of the physicians stated they did not want the HMA to meet with the industry to develop better communications. Subsequently, it was learned that a San Francisco firm has been engaged by the HSPA to conduct a survey and make suggestions to guide the plantations in future plans for handling the medical care of their employees. A Mr. James of the surveying firm met with Dr. Tomita and advised that this was a long-term, long-range project. It would appear that no changes can be contemplated within the next year insofar as plantation policies are concerned and the problems involving Medicare claims will probably not be resolved to the satisfaction of the physicians involved.

(4) Two meetings have been held with HMSA in 1967. All counties sent representatives except Kauai. A third meeting was deferred pending instructions from the counties on what direction future negotiations, if any, should take. Honolulu has advised that negotiations should be suspended until such time as HMSA agrees to the basic principles which are essentially those set forth at the last meeting of the House of Delegates. Kauai has asked that negotiations continue. Maui voted to discontinue negotiating with HMSA. Hawaii has not yet been heard from. It is regrettable that the committee is unable to report progress in this area.

RECOMMENDATIONS: (1) That the Negotiating Committee continue to work with the Department of Health in an effort to effect a change over to a fee-for-service basis for the physicians working in its clinics and conferences and that in the meantime the HMA members be urged to continue to provide the needed services through the coming fiscal year, even though this results in a financial loss to them. In the meantime, it is further recommended that the physicians bill on a fee-for-service basis in order that the cost of such a program can be determined. (2) That the committee continue to work with the DSS to try to effect adjustments in the unsatisfactory aspects of the current program and that the goal to provide free choice of physician and facility to all DSS clients continue to be pursued. (3) That the committee meet with the industry to try to effect better communications with the physicians and that it work with individual plantation physicians if they so request. (4) That the House of Delegates reaffirm the basic principles, with slight revisions to meet current status, on which negotiations with HMSA be pursued; i.e. (a) That the master and individual contracts be executed for a stipulated period of time and expire simultaneously. (b) That the Review Committee be a State-appointed committee and if disciplinary action is thought to be in order, referral should be made to the appropriate county society. (c) The Association should review and approve all plans before they are offered for sale. (d) That the nomination of physicians for the HMSA Board of Directors be on the basis of one nominee for one vacancy regardless of whether the nomination is made by the entire county society or its executive body. (e) That no items be transferred from the Administrative Operating Procedures to the General Information Section of the Physician's Handbook without prior approval of the Association. (5) That further negotiations with HMSA be deferred until affirmative action is taken by HMSA on the basis of one nominee for one vacancy regardless of whether the nomination is made by the entire county society or its executive body. (e) That no items be transferred from the Administrative Operating Procedures to the General Information Section of the Physician's Handbook without prior approval of the Association. (5) That further negotiations with HMSA be deferred until affirmative action is taken by HMSA on the basic principles as set forth in recommendation four.

CHEW MUNG LUM, M.D.

*Negotiating Committee*

A full and complete discussion was had on the subject.

Your Reference Committee recommends the adoption of this report and all five recommendations. However, there will be a minority report from Dr. Reppun.

*Minority Report on the Report of the Negotiating Committee*

With reference to recommendation four (4): In view of the long-standing stalemate in negotiations between the HMA and the HMSA; in view of the unshakable

position of our Association on all remaining points at issue, and in view of HMSA's apparent refusal to concede these points; in view of HMSA's embarkation upon a totally new concept of usual, customary, and reasonable fees without prior approval of HMA, it is moved that this House of Delegates instruct the Negotiating Committee to apprise HMSA that negotiations be terminated forthwith.

**ACTION:**

**It was voted not to adopt the minority report.**
**It was voted to adopt the majority report of the Referenee Committee.**

## REVIEW COMMITTEE

At the last meeting of the House of Delegates it was voted to urge each county to set up a claims review committee and further that there be a similar committee established at the state level which will act as an appeal body.

The state committee has not been called upon to act during the past year. In answer to the request that the counties set up their own review committees, only Hawaii replied.

The committee was asked to develop a definition of its functions for inclusion in the Bylaws and the following suggestion is submitted: The Review Committee shall hear and review complaints from the public, physicians, health insurance organizations, and government which have not been resolved at the county level or which involve more than one county.

An action by the Ohio State Medical Association came to the attention of the Chairman too late to be included in a meeting agenda. The House of Delegates may wish to adopt a similar policy statement for Hawaii. In Ohio they have stated that only a duly constituted medical society committee may appropriately review and pass on the justice of a physician's fee.

RECOMMENDATIONS: (1) That the House of Delegates adapt the Ohio State Medical Society's policy for Hawaii: Only a duly constituted committee of the Hawaii Medical Association or the appropriate county medical society may appropriately review and pass on the justice of a physician's fee. Neither the hospital management nor the hospital medical staff, nor any insurer, nor any hospital service association has the privilege or the right to demand an audit of staff members' personal financial records for any purpose. Any attempt on the part of the medical staff or insurer to compel such an audit is unethical.

RODNEY T. WEST, M.D.

*Review Committee*

Your Reference Committee next considered the report of the Review Committee. A full and complete discussion of the subject was had.

Your Reference Committee recommends that paragraph No. 3, sentence No. 2 be reworded as follows: "The Review Committee shall hear and review complaints and utilization problems from the public, physicians, health insurance organizations, hospitals, and government which have not been resolved at the county level or which involve more than one county." Your Reference Committee recommends approval of the committee's recommendation.

**ACTION:**

**The Chairman moved to adopt this portion of the report. After considerable discussion on whether to amend the Review Committee's recommendation, it was voted to adopt the Referenee Committee's report.**

## WORKMEN'S COMPENSATION COMMITTEE

The committee has been responsible for negotiating Workmen's Compensation fee schedules with the Department of Labor and making recommendations for changes in the Workmen's Compensation Law to the Legislative Committee.

Several meeetings were held with the Bureau of Workmen's Compensation regarding a revision of the schedule which had not been changed since January, 1962. Negotiations were held with Messrs. Douglas, Hasegawa, Laureta, and Dr. Dean Walker. A public hearing was held on November 3, 1966, in Honolulu, at which time the committee took about two hours to present its case showing that the Relative Value Studies adopted by the House of Delegates on April 30, 1965, were the basis of a great majority of the fees in the State. It was further established that the conversion factor used throughout the State was five or more. The mode was five and, therefore, this conversion factor was proposed as the one to be used by the Bureau of Workmen's Compensation. Prior to the hearing, postcards were sent to every member of the Hawaii Medical Association asking whether the Relative Value Study was being used and if a conversion factor below, at, or above five was being used.

Hearings were scheduled on Kauai, Maui, and Hawaii. The Department of Labor sent their own questionnaires to the doctors on these islands. We copied the questionnaire and sent it out for our own information. Dr. Tomita and Mr. Rice were sent to the neighbor islands to present testimony at the hearings.

At the time the cards were sent out, it was estimated that 655 of the HMA members were in private practice. There were 609 returns and all but 86 indicated they used the RVS. Of these, 86 said they did not use the RVS. Many were psychiatrists, and 72 were on Oahu. Twenty-one (12 on Oahu) said they used a conversion factor of less than five, 287 (236 on Oahu) used five, and 204 (201 on Oahu) more than five. One physician failed to check a category. Returns of the duplicate questionnaires sent to the neighbor island members indicated as follows only: On Hawaii with 50 practicing physicians there were returns from all but eight. Six do not use the RVS. Of the 35 that do, one uses a conversion factor of less than 4.5, 31 at 5, and four at more than 5. Of the four using a conversion factor of more than five, only one uses this factor all of the time. On Kauai, all 12 physicians returned the questionnaire. Two do not use the RVS. Seven convert at five and three at more than five. Of the three that convert at more than five, only one uses this conversion factor for all patients. On Maui with 34 practicing physicians, there were 30 returns, all of whom use the RVS. All use five for a conversion factor except that six use a conversion factor of more than five some of the time, and one uses a lower conversion factor occasionally.

The 1965 Relative Value Studies were accepted as the basis for the Bureau of Workmen's Compensation fees, using a conversion factor of five. These fees went into effect February 15, 1967, a fact which was confirmed by an article in the *Star-Bulletin*.

The Legislature has been asked to change the law to require periodic fee surveys, not less than once every three years, and to make the fee schedule statewide. The reason two years was chosen was that by the time the new publication is out, it will be approximately three years. If three years is asked, it will actually be four. At the present time, the law reads that it is left up to the director of the Department of Labor to make the determination. This has been done arbitrarily and infrequently. These recommendations were channeled through the Legislative Committee.

When the new fee schedule for the Bureau of Workmen's Compensation is published, it will be gone over carefully before it is adopted by this committee and if any changes are needed, further negotiations will be carried on with the Bureau of Workmen's Compensation. I believe that the new director will probably be Mr. Robert Hasegawa.

I think in the future that our negotiations with the Bureau of Workmen's Compensation will be made much easier by the fact that we have our own Relative Value Studies in this State, and it has been accepted. Before, two things would come up at the hearings: (1) we did

not have our own study, but we are trying to use California's, and (2) that the HMSA schedule represented the usual and customary fees in this State.

RECOMMENDATIONS: (1) That the committee remain active and keep itself informed at all times of the need for revisions in both the fee schedule and the law. (2) That each item of the published Workmen's Compensation fee schedule be screened to see that the Hawaii RVS converted at five has been used. (3) That the HMA work towards developing an ongoing formula for providing periodic fee schedule adjustments based on changes in the cost-of-living indexes.

DON E. POULSON, M.D.

*Workmen's Compensation Committee*

Your Reference Committee next considered the report of the Workmen's Compensation Committee. A full and complete discussion of the subject was had.

Your Reference Committee recommends that recommendations No. 1 and 2 be approved.

Your Reference Committee recommends that recommendation No. 3 be reworded as follows: "That the HMA work towards developing a formula for providing periodic fee schedule adjustments, for example, based on changes in the cost-of-living indices."

**ACTION:**

**The Chairman moved adoption of this portion of the report. It was adopted.**

## AD HOC COMMITTEE ON INHOSPITAL MEDICAL EDUCATION

This ad hoc committee evolved from a joint meeting on February 24, 1967, of the Medical Education, Medical Care Plans and Fees, Hospital, and Indigent Medical Care Committees of the HMA. It was assigned the task of developing guidelines for medical education programs as they relate to PL 89-97. It is composed of two representatives from each of the four committees that participated in the joint meeting.

The basic concern of this committee was to explore and develop methods for preserving and improving the medical education programs with the implementation of PL 89-97. The directors of medical education from the various hospitals gave strong testimony to the Medical Education Committee that the preservation of the "staff" patients is vital to the maintenance of a high-quality intern and residency training program. The full implementation of PL 89-97 threatens to eliminate the "staff" patients unless some mechanism within the medical profession is developed to preserve this segment of patients. To this end, lengthy discussions and hearings were held at two meetings and the following guidelines were developed:

(1) Each hospital and its medical staff should determine the extent of its medical education program and its pattern of relationship with PL 89-97. These programs should be in accordance with the hospital staff bylaws and the Principles of Medical Ethics as set forth by the American Medical Association.

(2) The medical staff of a hospital or any part thereof may form an association for the purpose of promoting medical education, the structure and operation of which must be legal and conform to the staff bylaws and the AMA Principles of Medical Ethics.

(3) Substandard fees should not be charged for physician services in a teaching hospital.

(4) No hospital should profit from the work of a physician.

(5) Separate funds may be developed by the medical staff, to serve as a supplement to the educational program provided contributions are voluntary.

The philosophy and intent of the committee was to provide rather broad guides so that each hospital staff could develop its own program that would serve its situation and attitudes best. The committee recognizes that guides and principles suffer from the inherent deficiencies in language and are all too fallible and subject to distortion by interpretation. However, each medical staff shoud find well-defined guides in its staff bylaws and the AMA Principle of Medical Ethics.

RECOMMENDATIONS: (1) That the guides as set forth in this report be adopted and disseminated to the chief of staff of each non-Federal hospital. (2) That this ad hoc committee be continued to serve any institution requiring review of their plans.

RICHARD MAMIYA, M.D.

*Ad Hoc Committee on Inhospital Medical Education*

Your Reference Committee next considered the report of the Ad Hoc Committee on Inhospital Medical Education.

Your Reference Committee recommends that guidelines No. 1, 2, 3, and 5 be approved.

Your Reference Committee recommends that guideline No. 4 be reworded as follows: "No hospital should derive monetary profit from the work of a physician."

Your Reference Committee recommends a sixth guideline be added; to wit, "That physicians participating in these services whether for educational training programs or not, shall be the sole arbiters of the disposition of their fees without mandate or coercion."

Your Reference Committee recommends approval of recommendations Nos. 1 and 2.

**ACTION:**

**The Chairman moved adoption of this portion of the report. It was adopted.**

## CHRONIC ILLNESS AND AGING COMMITTEE

Hospitalization of patients in extended care facilities became a benefit under Medicare on January 1, 1967. It was noted that 14 extended care facilities having a bed capacity of approximately 1,000 beds have been approved by the Department of Health. Seven of these extended care facilities are part of hospitals. It is felt by the Department of Health that there are adequate extended care facility beds at the present time. The average occupancy of the above-noted 1,000 beds is approximately 90%. It is expected that 200 additional extended care beds will be approved per year, and that this will keep pace with the increasing need for extended care beds.

The summary report of the Honolulu Home Care Service based at St. Francis Hospital for the period July 1 to December 31, 1966, was reviewed. During this period, home health services were included as one of the benefits of Medicare. It was noted that the census on December 31, 1966, was 74 patients in comparison to 49 patients on July 1, 1966. An increase in the percentage of referred patients who were 65 years or older was noted. For the six-month period 70.9% of the patients were in this category, compared to a previous high of 55.5%. It was also noted that 70% of the referrals listed Medicare as the source of payment. For the same six-month period in 1965, 48% of the referrals were 65 years of age or more and would have qualified under Medicare. It is apparent that the primary financial coverage for home health care has shifted to Medicare. DSS, HMSA, and to a lesser extent Industrial Compensation Insurance are also sources of payment. An additional service, that of Home Health Aides, was instituted in September, 1966. These Home Health Aides perform services similar to those performed by nurses aides in hospitals. It was noted that a full-time director for the Home Care Service was necessary because of the expansion of the program, and that Mrs. Rose Ann Poyser was appointed the full-time director on March 1, 1967.

It was discovered that the City and County of Honolulu is charging the Medicare insurance carrier $1.00 per visit for physician visits to patients in extended care beds. It was also noted that this charge of $1.00 per visit is made per day regardless of the extent of the physician visit. The physicians, who are on salary basis, then sign the fees collected back to the City and County. This problem was referred to the Medical Care Plans Committee for further study.

The problem of timing in pronouncing patients dead at extended care facilities and nursing homes was discussed. It was a feeling of some that if a patient expired at two or three in the morning, the physician could wait until he makes his rounds to officially pronounce him dead. However, no particular procedure was approved, and the problem will be followed further.

The plan of Dr. Dudley Seto to apply for a USPHS grant to establish a dialysis center for chronic kidney disease was approved in principle.

RECOMMENDATIONS: (1) The committee should continue to support the Department of Health in its efforts to up-grade the standards of extended care facilities and nursing homes, in order that the number of approved beds can keep pace with the growing needs. (2) The committee should continue to review the progress of ongoing programs such as the Honolulu Home Care Service.

GORDON LIU, M.D.

*Chronic Illness and Aging Committee*

Your Reference Committee next considered the report of the Chronic Illness and Aging Committee. A full and complete discussion of the subject was had. Your Reference Committee recommends approval of both recommendations.

**ACTION:**

**The Chairman moved adoption of this portion of the report. It was adopted.**

## HOSPITAL COMMITTEE

The committee met monthly, except September and February. The major issues concerning this committee during the year have been:

The relationship of hospital-based specialists in the matter of fees to the Department of Social Services for its clients who are seen as inpatients or outpatients. A dilemma exists in that the DSS maintains its contract is with the hospitals and that fee-for-service charges are not part of the per diem hospital contract rates or part of the all-inclusive outpatient visit rates. This position is also maintained by the hospitals involved who state they cannot negotiate contracts for the physicians to provide services to the DSS clients. Ethically, the hospitals are correct in this stand. The matter is being pursued further by this committee in investigating a complaint from a physician regarding nonpayment of fees for radiology services provided to DSS clients.

The committee has also studied the problems of billing of Medicare patients who are treated in existing hospital training programs. This particular problem is being met, in part, by an ad hoc committee study on the acceptable form of handling Title XVIII and Title XIX patients. Guidelines will be presented to the House of Delegates from this ad hoc committee.

The committee has also reviewed a complaint of a physician relative to the loss of staff privileges at a local hospital. This matter is still under investigation.

Other subjects covered by the committee have been information from the hospitals on the modes of operation of employee health services, referral of request from Tahiti for physician and hospital fees in Honolulu, approval of a form for use in transferring patients from an acute hospital to an extended care facility, and a review of the concept of "Association of Physicians" to manage Title XVIII and Title XIX patients in hospital teaching programs.

The chairman wishes to commend committee members on their diligence and advice in the past meetings and their cooperation in seeking a broader liaison with the Hawaii Hospital Association.

RECOMMENDATIONS: A thorough study of the problem of providing physicians' services for Title XIX patients in hospital outpatient clinics and the problem of disposition of fees accruing from these services has led to the following recommendations: (1) That physicians bill for their services in full to the appropriate agency. (2) That, as much as possible, patients in this category (Title XIX) be given free choice of physician. (3) That physicians participating in these services, whether for educational training programs or not, shall be the sole arbiters of the disposition of their fees without mandate or coercion.

It is felt that these recommendations would be most acceptable ethically and could be implemented without endangering current teaching programs.

KEITH F. O. KUHLMAN, M.D.

*Hospital Committee*

Your Reference Committee next considered the report of the Hospital Committee. A full and complete discussion of the subject was had. Your Reference Committee recommends approval of all three recommendations and calls attention to the inclusion of recommendation No. 3 in the adopted guidelines of the Ad Hoc Committee.

**ACTION:**

**The Chairman moved adoption of this portion of the report. It was adopted.**

## MEDICAL EDUCATION COMMITTEE

The committee had seven meetings during the year and concerned itself with matters relating to the University of Hawaii Medical School and the hospital postgraduate training programs.

The Dean of the Medical School presented three issues for consideration and recommendations by the Association. After appropriate hearings and discussions the following actions were passed on these issues: (1) The committee strongly endorse the formation of high-quality clinical departments with full representation in the planning and organizational structure of the medical school. (2) The committee go on record as welcoming the opportunity for members of the HMA to serve on the Advisory Board assisting the University of Hawaii in its clinical appointment. (3) Under the present organization of the University of Hawaii Medical School, the Medical Education Committee of the HMA voted to go on record favoring that full-time faculty members be allowed to engage in a limited physician referral consultation practice; that the consultants should charge a reasonable fee; and that the disposition of this fee be left to the administration of the medical school.

These were presented to the HMA Council but were not approved because they were proclaimed not in accord with the AMA Principles of Medical Ethics. This matter was reviewed and the proposal was reworded to read: Under the present organization of the University of Hawaii School of Medicine, the Medical Education Committee of the HMA voted to go on record favoring that full-time faculty members be allowed to engage in a limited physician-referral consultation practice; that the consultants should charge a reasonable fee; and that this fee should not be used to supplement the income of the full-time salaried faculty members, but that its disposition should be at the discretion of the participating consultants. This action will be resubmitted to the Council for consideration and action.

The committee was much concerned with the future of the intern and resident training programs in our community in view of the proposed Federal and State legislation on health care. The availability of patient material for training physicians could be severely curtailed by the full implementation of PL 89-97. Separate meetings were held with the directors of medical education from all the hospitals with training programs and with the hospital administrators. Out of this came a strong endorsement for medical education and an urgent need for the preservation of the postgraduate training programs as presently organized.

In the effort to maintain our postgraduate training program, a joint meeting incorporating the Medical Education, Medical Care Plans and Fees, Hospital, and Indigent Care Committee was held to consider this issue. From

this meeting, it was voted to form an ad hoc committee composed of representatives from each of these committees to develop guidelines for medical education programs as it relates to PL 89-97. The ad hoc committee developed a resolution in this regard which was presented to the Council and is covered in a separate report.

The Association sent the chairman to the AMA Council on Medical Education meeting in Chicago and helpful ideas and impressions were brought back.

The Millis report on "The Graduate Education of Physicians" will be discussed at the committee meeting on May 8. This report, if adopted, will have far-reaching effects on medical practice and the education of physicians. The effect will be comparable to changes that evolved after the adoption of the Flexner report of 1910. This report merits careful study not only by committees of our Association, but by each individual in the Association. Reactions should be relayed to the appropriate body. The report recommends such drastic changes as the elimination of intern and resident training programs and general practitioners, as we know them today, and centralization of all phases of prostgraduate education under one central body. A further recommendation to the House of Delegates may be developed by the committee after its next meeting.

RECOMMENDATIONS: (1) This committee should maintain close liaison with the postgraduate training programs and the University of Hawaii School of Medicine and provide service to enhance these programs. (2) A longer tenure than one year and staggered appointments would be desirable for members of this committee, especially at this time, because of the many and rapid developments in this area. There would be better continuity and better efficiency and productivity on the part of the members.

RICHARD MAMIYA, M.D.

*Medical Education Committee*

Your Reference Committee next considered the report of the Medical Education Committee. A full and complete discussion of the subject was had.

Your Reference Committee recommends that the Council's position as stated in paragraph No. 3, sentence No. 2, be reworded as follows: "Under the present organization of the University of Hawaii School of Medicine, the HMA go on record favoring that full-time licensed faculty members be allowed, at the University of Hawaii School of Medicine's discretion, to engage in a limited physician-referral consultation practice; that the consultant should charge a reasonable fee; that the disposition of this fee should be at the discretion of the participating consultant; and that these full-time faculty members be encouraged to join their county medical society."

Your Reference Committee recommends approval of both recommendations.

**ACTION:**

**It was voted to amend the report to strike out that portion which reads as follows: "the Council's position as stated in—."**

**The Chairman moved the adoption of this portion of the report as amended. It was adopted.**

## PHARMACY COMMITTEE

The committee met on several occasions throughout the year, discussing legislation and related pharmacy matters.

Probably the most important meeting was held with the Department of Social Services of the State of Hawaii regarding the use of a formulary. As you know, very little was achieved by this meeting inasmuch as the formulary had already been prepared. At the time of the meeting we requested of the Department of Social Services a meeting with Mr. William Among, Chief of the Department of Social Services, but to date no meeting has been accomplished. Mr. Among has indicated his willingness to meet with us, and a meeting will be scheduled. It is felt that more meetings of the Pharmacy Committee may be necessary in the ensuing year to keep abreast of the formulary problem, both on the national and local levels. It is the feeling of the committee, with a few minor dissents, that it is not necessary to have a formulary if the physicians will use discretion in the ordering of medications, not only for their own private patients but those who come under Department of Social Services' jurisdiction. In this regard it is the feeling of the committee that the request of the Federal and State governments for the use of the formulary for these patients places them in the category of receiving drugs at the dictate of the government rather than at the discretion of the physician. In this regard it is felt that this is an invasion of the right of the physician to practice as he deems best in the best interests of the patient.

Furthermore, it is the feeling of the committee in general that this in effect relegates this group of patients to the type of care which is in a somewhat secondary category as would be handled in the case of our regular private patients. We feel that this in itself is defeating one of the purposes for which the Medicare Titles XIX and XVIII were established.

The committee wishes to thank the President of the Association and Dr. Goto, Chairman of the Legislative Committee, for their cooperation during the past year.

RECOMMENDATION: (1) That the Hawaii Medical Association go on record as opposing a mandatory formulary which prevents the physicians from using their best judgment in the treatment of patients whose bills are paid by the Department of Social Services.

JOHN F. CHALMERS, M.D.

*Pharmacy Committee*

Your Reference Committee next considered the report of the Pharmacy Committee. A full and complete discussion of the subject was had.

Your Reference Committee recommends that the recommendation of this committee be reworded as follows: "That the Hawaii Medical Association go on record as opposing any mandatory formulary which prevents the physicians from using their best judgment in the treatment of patients."

**ACTION:**

**The Chairman moved adoption of this portion of the report. It was adopted.**

## REPORT ON FIRST NATIONAL CONGRESS ON THE SOCIO-ECONOMICS OF HEALTH CARE, CHICAGO, ILLINOIS, JANUARY 22-23, 1967.

The full text of this report appears in the scientific section of the JOURNAL.

*Report on First National Congress on the Socio-Economics of Health Care, Chicago, Illinois, January 22-23, 1967.*

Your Reference Committee recommends that this report be published in the HAWAII MEDICAL JOURNAL in its entirety, and wishes to thank Dr. West for making a complete report.

**ACTION:**

**The Chairman moved adoption of this portion of the report. It was adopted.**

## RESOLUTION NO. 8

Re: Workmen's Compensation Hearings

WHEREAS, Even though the Department of Labor held one public hearing, five years passed without a revision in the Workmen's Compensation Fee Schedule; and

WHEREAS, The Council voted to institute legal proceedings if a public hearing was not scheduled and satisfactory fee schedules were not made; and

WHEREAS, It was necessary to develop both statistical and legal testimony for the Department of Labor's public

hearings which took place November 3, 1966, March 30, 31, and April 3, 1967; and

WHEREAS, The services of Kazuhisa Abe, Attorney-At-Law, were sought to assist in the preparations and presentations; and

WHEREAS, In answer to our request for a bill covering services rendered Mr. Abe replied, in part, to our President, Dr. Theodore T. Tomita: "I am not planning and will not send a statement for my services because of my close friendship with you and for the many services you rendered to us members of the State and Territorial Legislature during my term of office from 1952 to 1966. I, especially appreciate the time and effort you spent in counselling and advising me in connection with the hospital and medical matters which were pending before the various sessions of the Legislatures"; and

WHEREAS, The Hawaii Chamber of Commerce in its Legislative Action Bulletin No. 8 estimated that the revision of the fee schedule for Workmen's Compensation represents an additional cost of $700,000 annually; and

WHEREAS, The members of the Hawaii Medical Association have benefited considerably from the services of Mr. Abe; now, therefore be it

*Resolved,* That the House of Delegates in behalf of the entire membership of the Hawaii Medical Association in gratitude for the invaluable services rendered and altruism displayed express its thanks to Kazuhisa Abe for his invaluable and generous assistance.

Submitted by DON E. POULSON, M.D.

*Resolution No. 8*

**ACTION:**

**The Chairman moved that the resolution be adopted. It was adopted.**

## RESOLUTION NO. 10

Re: Workmen's Compensation—Usual and Customary

WHEREAS, The usual-and-customary-fee concept is becoming more prevalent in the payment of physicians' fees by third parties; and

WHEREAS, Recent surveys show that not all physicians in the State of Hawaii charge the same fees; and

WHEREAS, The usual-and-customary-fee concept is the most equitable method of paying physicians' fees; and

WHEREAS, Adjustments in the Workmen's Compensation Fee Schedule are slow in evolving; now, therefore be it.

*Resolved,* That the Administrative Director of the Division of Industrial Accidents of the Department of Labor and Industrial Relations be urged to continue to progress in medical economics by adopting the usual-and-customary-fee concept for Workmen's Compensation cases; and be it further

*Resolved,* That the appropriate committee of the Hawaii Medical Association undertake to negotiate with the Administrative Director to this end.

Submitted by J. MARK B. SOWERS, M.D.

*Resolution No. 10*

**ACTION:**

**The Chairman recommended that the resolution not be adopted. It was not adopted.**

## RESOLUTION NO. 11

Re: Standard Insurance Forms

WHEREAS, The amount of time spent by doctors and their office staffs in preparing insurance forms is increasing and is made more complex by an increasing number of different insurance forms; and

WHEREAS, It has been some time since the Hawaii Medical Association has met with representatives of the Health Insurance Council; and

WHEREAS, There is a need for developing means of keeping doctors' overhead expenses as low as possible because it is a part of the total cost of medical care; now, therefore be it

*Resolved,* That an appropriate committee of the Hawaii Medical Association be designated to develop and promote the use of a standard reporting form for all private and government third-party payment programs.

Submitted by J. MARK B. SOWERS, M.D.

*Resolution No. 11*

**ACTION:**

**The Chairman moved that the resolution be adopted. It was adopted.**

## RESOLUTION NO. 13

Re: Drug Formularies

WHEREAS, The distribution of the formulary proposed by the Department of Social Services has focused attention on the deleterious effects of such restrictions on the physician's medical judgment; and

WHEREAS, The health of the public is endangered by the restrictions placed upon physicians who are required to prescribe within the limits of such a drug formulary; and

WHEREAS, The people of this State whose medical bills are paid for by the State of Hawaii should not be discriminated against by being forced to receive inferior medical treatment; now therefore be it

*Resolved,* That the House of Delegates of the Hawaii Medical Association go on record as endorsing the principle that any drug formulary is by its nature restrictive and inhibits the proper treatment of patients; and be it further

*Resolved,* That the Hawaii Medical Association take all possible steps to eliminate the drug formulary under the Department of Social Agencies medical payments program.

Submitted by J. MARK B. SOWERS, M.D.

*Resolution No. 13*

**ACTION:**

**The Chairman recommended that the resolution not be adopted. It was not adopted.**

## RESOLUTION NO. 15

Re: A Four-year School of Medicine

WHEREAS, The two-year medical school program at the University of Hawaii has received wholehearted support from the medical profession of Hawaii, individually and collectively; and

WHEREAS, A much better education program in medicine can be provided by a four-year school of medicine; and

WHEREAS, Hawaii can and should play a major role in providing medical, educational, and health service opportunities for its own residents and for residents of the Pacific basin; and

WHEREAS, The Hawaii Medical Association supports all efforts to improve the quality of medical education; now, therefore be it

*Resolved,* That the Hawaii Medical Association endorse the expansion of the University of Hawaii's School of Medicine from a two-year to a four-year school as soon as such expansion becomes financially feasible; and be it further

*Resolved,* That the Hawaii Medical Association urge the Legislature to explore possible means of funding a four-year medical school; and be it further

*Resolved,* That upon its adoption copies of this resolution be transmitted to President Thomas Hamilton and Dean Windsor Cutting, of the University of Hawaii, and to the Governor of Hawaii and the members of the State Legislature.

Submitted by the MEDICAL EDUCATION COMMITTEE

*Resolution No. 15*

**ACTION:**

**The Chairman moved that the resolution be adopted. It was adopted.**

**RESOLUTION NO. 16**

Re: Payment of Part-time University Physician Faculty Members

WHEREAS, The Hawaii Medical Association recognizes the economic problems faced by the new University of Hawaii School of Medicine; and

WHEREAS, Members of the Hawaii Medical Association are concerned about these financial problems; now, therefore be it

*Resolved,* That the Hawaii Medical Association urge all of its members who are devoting less than one-quarter time to the University's teaching program to neither seek nor accept remuneration from the University of Hawaii School of Medicine during the academic year 1967 through 1968; and be it further

*Resolved,* That upon its adoption copies of this resolution be transmitted to President Thomas Hamilton and Dean Windsor Cutting of the University of Hawaii.

Submitted by the MEDICAL EDUCATION COMMITTEE

*Resolution No. 16*

Your Reference Committee recommends the following revisions:

First *Resolved,* That the Hawaii Medical Association commends those members who are devoting time to the University's teaching program without remuneration from the University of Hawaii School of Medicine during the academic year 1967 through 1968;

Second *Resolved,* That the Hawaii State Legislature be urged to provide sufficient funds to adequately compensate these physicians after the 1967-68 academic year;

Third *Resolved,* That upon its adoption copies of this resolution be transmitted to President Thomas Hamilton and Dean Windsor Cutting of the University of Hawaii, the Governor of the State of Hawaii, and all members of the Legislature.

**ACTION:**

**It was voted to substitute a hyphen (-) for the word through in the first Resolved.**

**The Chairman moved the adoption of this resolution as amended. It was adopted.**

**RESOLUTION NO. 17**

Re: University School of Medicine Faculty

WHEREAS, The Hawaii Medical Association recognizes the need for unity among the teaching, practicing, and researching sections of the medical community; and

WHEREAS, The creation of two medical faculties—one, the so-called clinical faculty composed predominantly of practitioners who serve the University without pay, and the other the academic faculty who are paid and represented in the University affairs—tends to produce disunity and disharmony within the medical profession; and

WHEREAS, Such a designation as clinical instructor or professor serves no useful purpose; now, therefore be it

*Resolved,* That the Hawaii Medical Association urge the administration of the University of Hawaii School of Medicine to create one faculty composed of full-time and part-time teachers whose remuneration and representation within the University would be dependent upon the proportion of time devoted to teaching and related activities; and be it further

*Resolved,* That upon its adoption copies of this resolution be transmitted to President Thomas Hamilton and Dean Windsor Cutting of the University of Hawaii.

Submitted by the MEDICAL EDUCATION COMMITTEE

*Resolution No. 17*

**ACTION:**

**The Chairman moved that the resolution be adopted. It was adopted.**

**RESOLUTION NO. 21**

Re: Certification and Future Training of the Family Physician

WHEREAS, The American Medical Association Ad Hoc Committee on education for family practice, the AAGP Committee on requirements for certification, the Millis Commission, and the Folsom Commission unanimously agreed that the primary need in medicine today is to provide continuing comprehensive personal and family health service of high quality; and

WHEREAS, The above committees and commissions also unanimously agreed that the family physician is the key professional person in providing and coordinating continuing comprehensive personal health service for the entire family; and

WHEREAS, There is a need to stimulate interest in family practice and to continue to improve the quality of care provided; and

WHEREAS, The primary purpose or goals of a certifying board in family practice are: (1) To improve the quality of medical care provided to the public, (2) to assure availability of physicians to provide comprehensive care, (3) to improve the qualifications of the physicians delivering this comprehensive care, and (4) to provide meaningful recognition for physicians trained to provide comprehensive care; now, therefore be it

*Resolved,* That the Hawaii Medical Association through its House of Delegates support the concept of family practice as a primary specialty and give support to efforts by the American Medical Association and AAGP in attaining board certification for family physicians and in developing the curriculum to be followed in medical school and residency training of future comprehensive care physicians; and be it further

*Resolved,* That the delegate or delegates to the annual American Medical Association convention in June be instructed to give dynamic support to any measures consistent with the above resolution.

Submitted by the
HAWAII ACADEMY OF GENERAL PRACTICE

*Resolution No. 21*

Your Reference Committee recommends that the last Resolved be reworded as follows: "Resolved, That the delegate or delegates to the annual American Medical Association Convention in June be instructed to present this Resolution and to give dynamic support to any measures consistent with it."

**ACTION:**

**It was voted to amend the last Resolved to read as follows: "*Resolved,* That the Hawaii Delegation to the annual American Medical Association Convention in June be permitted to convey the intent of this Resolution, and to give dynamic support to any measures consistent with it."**

**The Chairman moved the adoption of this resolution as amended. It was adopted as amended.**

**RESOLUTION NO. 24**

Re: Surgical Utilization

WHEREAS, There is increasing evidence that there will be disputes on payment of Part A benefits under Medicare Title XVIII; and

WHEREAS, These disputes will be on the basis of utilization; and

WHEREAS, Since there now exists no authoritative voice

to define the limits of surgical utilization in points of dispute among hospital and utilization committees and third parties; and

WHEREAS, The Hawaiian Surgical Association is the official representative body for the specialty of surgery within the State of Hawaii and as such is the informative source for the Hawaii Medical Association, now, therefore be it

*Resolved,* That the Hawaii Medical Association recognize the role of the Hawaiian Surgical Association in providing authoritative guidelines pertaining to surgical utilization, particularly as a source of information to resolving disputes between hospital utilization committees and third parties.

Submitted by KEITH F. O. KUHLMAN, M.D.

*Resolution No. 24*

**ACTION:**

**Dr. Kuhlman said the resolution was submitted by the Hawaiian Surgical Society.**

**The Chairman recommended that the resolution not be adopted.**

**It was voted to amend the last Resolved to read as follows: "*Resolved.* That the Hawaii Medical Association recognize the role of the Hawaiian Surgical Association in providing authoritative guidelines pertaining to surgical utilization, particularly as a source of information to resolving disputes between hospital utilization committees and third parties, and that all other specialty societies be considered as similar resource agencies." The resolution was adopted a samended.**

**The Chairman moved the adoption of the report as a whole as amended. It was adopted.**

Your Reference Committee Chairman wishes to thank the members for their hard work in the preparation of this report.

## NOMINATING COMMITTEE

The Nominating Committee of the Hawaii Medical Association has completed its meeting and has prepared the following slate of officers for the Hawaii Medical Association for 1967-68:

President-Elect.....*Robert M. Miyamoto, M.D.*
Treasurer.....*Herbert Y. H. Chinn, M.D.*
AMA Delegate.....*Richard D. Moore, M.D.*
*George H. Mills, M.D.*
Alternate AMA Delegate.....*John J. Lowrey, M.D.*
*Samuel D. Allison, M.D.*
Councillor from Maui.....*Wm. E. Iaconetti, M.D.*
Councillor from Hawaii....*Raymond T. Eklund, M.D.*

A discussion was held on whether or not the position of Delegate and Alternate Delegate to the AMA should be rotated frequently or whether incumbents should be kept in office for long periods of time. It was decided that this was a matter for the Bylaws Committee to decide. No further meetings were held.

CHARLES S. BROWN, M.D.

*Nominating Committee*

The President read a letter from John J. Lowrey withdrawing his name as a nominee for Alternate Delegate to the AMA.

Dr. George Mills withdrew his name as nominee for Delegate to the AMA.

**ACTION:**

**The President asked for nominations from the floor. David Wm. Jones was nominated for Counciler from Hawaii since Dr. Raymond Eklund is retiring and will be leaving the State. George H. Mills and Ogden D. Pinkerton were nominated for Alternate Delegate to the AMA.**

**The following tellers were appointed: Thomas P. Frissell, J. Mark B. Sowers, Grover H. Batten, Keith F. O. Kuhlman, and W. W. Goodhue.**

**Nominations were sought for the Nominating Committee. The following were nominated: Thomas P. Frissell, Robert K. Mookini, Marion Hanlon, Theodore T. Tomita, Coolidge Wakai, Raymond Tamura, Pete T. Okumoto, John J. Lowrey, William W. L. Dang, Burt O. Wade, and Rodney T. West.**

The results of the election were announced as follows:

President-elect.....*Robert M. Miyamoto*
Treasurer.....*Herbert Y. H. Chinn*
Councilor from Hawaii.....*David Wm. Jones*
(three years)
Councilor from Maui.....*William E. Iaconetti*
(three years)
Nominating Committee.....*William W. L. Dang*
*Thomas P. Frissell*
*John J. Lowrey*
*Theodore T. Tomita*
*Coolidge Wakai*
*Marion Hanlon* (Maui)
*Pete T. Okumoto* (Hawaii)
*Burt O. Wade* (Kauai)
Delegate to the AMA.....*Richard D. Moore*
Alternate Delegate to
the AMA.....*George H. Mills*

## NEW BUSINESS

The President asked if there were any new business to come before the House.

**ACTION:**

**It was voted to permit Dr. Richard Moore to present a new resolution to the House.**

WHEREAS, The President of this Association, Dr. Theodore T. Tomita, has given many hours of time and unswerving devotion during his term of office; and

WHEREAS, His efforts have contributed greatly to the advancement of professional knowledge and the welfare of the community; now, therefore be it

*Resolved,* That this House of Delegates of the Hawaii Medical Association express its admiration and appreciation by a standing vote of thanks.

**ACTION:**

**The resolution was adopted.**

**It was voted to have the Resolution as presented by Dr. Moore read at the HMA Banquet, Saturday night, May 20, 1967.**

## HB 76 OR LIBERALIZED ABORTIONS

There was considerable discussion re this matter. It was felt by several delegates that a more complete study should be given this matter before any final decision is made.

**ACTION:**

**It was voted that the House of Delegates instruct the President of the HMA to form an ad hoc committee to thoroughly study HB 76 and liberalized abortions and that a report be presented at an interim meeting or the next House of Delegates meeting.**

The meeting was adjourned at 6:45 P.M.

R. VARIAN SLOAN
*Secretary*



# is Jane stubborn?

Well, a little perhaps. But she has reason on her side. As head of the Coagulation Research Unit at the Warner-Lambert Research Institute, Mrs. Jane Lenahan prepares and tests a great many coagulation reagents. Ours and others. Some that are commercially available and some purely experimental. With all her long experience, she's never changed her mind about one thing: Simplastin comes closest to the ideal standards for a thromboplastin reagent.

If Jane could show you through her laboratories, she'd point out the sound theoretical and practical basis on which the superior performance of Simplastin® is built. To achieve the utmost sensitivity, stability and reproducibility, Simplastin is made from a carefully controlled blend of brain and lung tissue. In a painstaking process never duplicated by any other manufacturer, these starting materials are purified and adjusted to assure optimum pH, particle size and number in the final product.

Equally as important as the things that go into Simplastin are those left out – no moisture, no artificial stabilizers (which could lengthen the patient's prothrombin time) and, of course, not even the least trace of blood (which would affect factor VII and X sensitivity). As a result, Simplastin is sensitive and reproducible, not only with normal plasma but where it counts the most: with dilute plasma and plasma from patients on anticoagulant therapy.

Sometimes, it pays to be just a little bit stubborn....

GENERAL DIAGNOSTICS Division Warner-Chilcott Laboratories, Morris Plains, N.J.

# HAWAII TECHNOLOGISTS' BULLETIN

*Official Publication of the Hawaii Society of Medical Technologists*

*Editor:* LOUISE WULFF, MT(ASCP), University of Hawaii

## *Meet Your Officers—1967-68*

*President*.....Gilbert Gima MT (ASCP)
Wahiawa General Hospital
*President-elect*.....James Yano MT (ASCP)
Kaiser Foundation Hospital
*Recording Secretary*.....Edna Roelofs MT (ASCP)
The Queen's Hospital
*Corresponding Secretary*....Kay Hamamoto MT (ASCP)
Pathology Associates Medical Laboratories
*Treasurer*.....Deanne Horie MT (ASCP)
Tripler Army Medical Center
*Board of Directors*.....Elaine Chang MT (ASCP)
Past President
Board of Agriculture and Forestry
Gretchen Asato MT (ASCP)
Hawaii State Hospital
Phyllis Sonoda MT (ASCP)
The Queen's Hospital

PRESIDENT: Gilbert is currently on the mainland attending the ASMT Convention in Miami, Florida. The next issue will carry highlights of his career and recent travels.

PRESIDENT-ELECT: James attended Boston College in Newton Heights, Massachusetts, and received his B.S. degree in Medical Technology from the University of Hawaii. He was a member of Phi Kappa Phi Honorary Society and interned at St. Francis Hospital.

He was Laboratory Supervisor and Teaching Supervisor at St. Joseph's Hospital in Alton, Illinois, before joining the staff of Kaiser Foundation Hospital in Honolulu where he presently holds the same two positions.

He served as Editor for HSMT 1963-64, Corresponding Secretary 1964-65, and Board of Directors and Chairman of the Legislative Committee 1966-67.

James has managed and coached Little League Baseball for several years and enjoys golf.

RECORDING SECRETARY: Edna obtained a B.A. degree in Bacteriology from the University of Texas in Austin. She interned in Charity Hospital School of Medical Technology in New Orleans, Louisiana.

After working in Texas as Staff Technologist and as Head Technologist in the Chemistry Department, she joined the staff at The Queen's Hospital in Honolulu where she was in charge of hematology and presently is in charge of bacteriology.

Edna served as Diabetic Survey Chairman 1966 for HSMT. She also participated in the recruitment program for science teachers in February, 1967, lecturing on bacteriology techniques.

CORRESPONDING SECRETARY: Kay was raised in Honokaa, Hawaii. She received her B.S. degree in Medical Technology from the University of Hawaii after interning at Kuakini Hospital.

She is employed by the Pathology Associates Medical Laboratories. Kay enjoys sewing and cooking.

TREASURER: Deanne is from Waimalu and obtained her B.S. degree in Medical Technology from the University of Hawaii. She interned at Tripler Hospital and was employed at Wahiawa Clinic, Professional Medical Laboratory, and Straub Clinic before returning to Tripler Hospital in January, 1966, where she is currently employed.

She has been a member of HSMT for four years. Deanne loves to swim and play volleyball and is kept busy at home with three children, Dean, Brenda, and Guy, ages 5 through 8.

BOARD OF DIRECTORS: Elaine is Past President of HSMT. She received her B.S. degree in Medical Technology from the University of Hawaii and interned at Tripler Hospital. She is employed by the Board of Agriculture and Forestry. Besides serving on several HSMT committees she has held the offices of Treasurer and Vice President. Elaine enjoys baseball games, bowling, music, and working with the Honolulu Community Theater.

Gretchen is from Pittsburgh, Pa. She received a B.S. degree in Medical Technology from Marquette University in Milwaukee, Wisconsin. She has worked in chemistry at St. Francis Hospital in Pittsburgh and was head of chemistry at St. Benedict's Hospital in Ogden, Utah. She also worked at The Queen's Hospital in Honolulu before her present employment at Hawaii State Hospital. She has been a member of HSMT since 1963 and served as Recording Secretary 1965-67. Gretchen and her husband, Dr. Herbert Asato, a dentist, have two children. She enjoys swimming and sewing.

Phyllis obtained a B.S. degree in Medical Technology from the University of Hawaii and interned at Tripler Army Hospital. She received an M.S.

degree in Clinical Pathology from Northwestern University, Chicago, Illinois. She was a graduate assistant under Dr. Opal Hepler while attending Northwestern and later worked at the Sisters of Mercy Hospital in Hamilton, Ohio, where she served as Chemistry Laboratory Supervisor. She returned to Honolulu to work at The Queen's Hospital as a Staff Medical Technologist, Senior Medical Technologist in charge of Chemistry, and presently as Assistant Chief Medical Technologist. She has served as HSMT Convention Committee Chairman, Convention Consultant, as well as Planning and Scope Committee Co-chairman 1966-68.

## *H.S.M.T.'s Scholarship— First Recipient*

Miss Ethel Nakagawa, beginning her internship year at St. Francis Hospital, is the first student to receive the Hawaii Society of Medical Technologists' $250 award. Although the scholarship is not set up competitively, it is a pleasure to say that Miss Nakagawa is an excellent student who has proven to be a very dependable individual.



While obtaining her education, she has been employed by the Libby Cannery and as a clerk-typist by the University of Hawaii. Previously she was awarded a $100 "Y" Grant for tuition.

In addition to being active in the Med Tech Club on campus, she is an adviser for a Y-Teen club. Her hobbies include taking instruction in the Japanese Tea Ceremony and in Flower Arrangement, plus an interest in cooking.

Miss Nakagawa lives with her parents, Mr. and Mrs. Hideo Nakagawa, at 424 Mokauea Street.

It is indeed satisfying to see this award go to such a capable recipient.

## *1967-68 Interning Students*

*Kaiser Medical Foundation Hospital*
Emily Ching
Claudia Minei

*Kuakini Hospital*
Mary Lum

*The Queen's Hospital*
Kory Go
Sharon Oshiro
Thelma Oshiro
Cheryl Wong

*St. Francis Hospital*
Pamela Hirai
Gail Kimura
Ethel Nakagawa

*Tripler Army Medical Center*
Annette Harada
June Kaneshiro
Karen Liu
Fusako Maehira
Carole Osaki
Fernando Reyes
Gail Sato
Gloria Shiroma
Rolin Soong
Aileen Suzui
Gail Takiguchi
Glorian Yamaki
Fumiko Yamasato
Joann Yamashita


**WILLIAMS MORTUARY**

*"CHAPEL OF THE CHIMES"*

**1076 S. Beretania St., Phone 52-587** **Ample Parking Adjoining Mortuary**

**OVER A CENTURY OF SERVICE**

*"Service measured not by gold but by the Golden Rule"*

***MEMBER***

National Selected Morticians, National Funeral Directors Association,
Order of the Golden Rule, Hawaii Funeral Directors Association

## *In Memoriam* *continued from 552*

in an honest election. The doctor was also a member of the Tax Board of Appeals, which may not have made him popular in some quarters.

In March, 1887, Dr. Kuehn was appointed government physician for Molokai in addition to his duties on Maui. However, by October of that year he was again at sea as surgeon on the S.S. "Australia," and he never returned to practice in the Islands. While he was serving aboard the "Australia," his friend, Gibson, was arrested and forced to leave Hawaii. Gibson's family and friends were informed that all mail addressed to him in San Francisco was being opened and read in Honolulu by his political enemies. From then on Gibson's mail was sent through U.S. Consul McKinley or, when the "Australia" was in port, by Dr. Kuehn.

Just when the doctor left the sea and returned to Philadelphia to practice is not known. However, Philadelphia newspapers gave a lot of space to Dr. Kuehn in 1905 when he met Miss Ida May Miller, the daughter of James C. Miller, a wealthy contractor, from whom she had inherited an estate valued at $200,000. Very shortly after meeting Miss Miller he gave up his practice to manage her estate, which she charged was being looted by relatives who were constantly hounding her. Near the end of 1906 Miss Miller disappeared, but by December she was in New York, claiming that she had been in Ireland trying to straighten out her father's affairs.

At that time she admitted to reporters that she and Dr. Kuehn were married, but since she was against marriage by law she and the doctor had been married by a contract, which was published. In 1913 she died, and the doctor inherited her estate. The couple had no children.

On May 11, 1934, Dr. Kuehn died in Philadelphia at the age of 74. ■

## *County Society Reports* *continued from 556*

concluded with a talk by Lt. Col. Thomas Cheitland on "Surgical Indications in Rheumatic Heart Disease."

### Honolulu

Approximately 196 members attended the May 2 meeting which was preceded by a film on "The Diagnosis and Management of Cancer of the Colon and Rectum." One new member, Dr. Frank McDowell, was introduced to the membership. Valerie Hanna, representing the Hawaii Association of Medical Assistants, spoke briefly about their organization and extended an invitation to the doctors to attend their May 31 meeting.

A panel consisting of Edward Yoshimura, Robert Millar, Will Henderson, Bob Grathwohl, and Dr. Wilbur Lummis discussed "The Impact of Government Medicine on Private Practice." Following announcements relative to the medical assistants' seminar, the meeting of the

*continued page 619*


# Tandearil®
oxyphenbutazone

*Therapeutic Effects:* Tandearil is a nonhormonal compound which may rapidly resolve inflammation and help restore normal joint function. Its action does not affect pituitary-adrenal function or impair immune responses. Its value in osteoarthritis is especially noteworthy because this disorder responds inconsistently to steroids and is often resistant to salicylates. Further, indomethacin is limited only to osteoarthritis of the hip, whereas oxyphenbutazone is effective in all forms of the disease.

*Contraindications:* Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently.

*Warning:* If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with great caution in the first trimester of pregnancy.

*Precautions:* Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patient should be closely supervised and should be warned to report immediately fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools or other evidence of intestinal hemorrhage. Make regular blood counts. Discontinue the drug and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

*Adverse Reactions:* The most common are nausea, edema and drug rash. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. Infrequently, agranulocytosis, or a generalized allergic reaction may occur and require withdrawal of medication. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported but cannot definitely be attributed to the drug. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

*Dosage in Osteoarthritis:* The initial daily dosage in adults is 300-600 mg. in divided daily doses. When improvement occurs, dosage should be decreased to the minimum effective level; this should not exceed 400 mg. daily, and is often achieved with only 100-200 mg. daily.

For complete details, please refer to full prescribing information. 6562-VI(B)R

*Availability:* Tablets of 100 mg.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York

Geigy

# Tandearil®
oxyphenbutazone

# helps osteoarthritic joints move again



3 out of 4 osteoarthritics completely or markedly improved

| | |
|---|---|
| Sperling, I.L.: 3 Years' Experience with Oxyphenbutazone in the Treatment of Rheumatic Disorders, Applied Therapeutics 6:117, 1964. | 76.9% of 407 patients |
| Watts, T.W., Jr.: Treatment of Rheumatoid Disorders with Oxyphenbutazone, Clin. Med. 73:65, 1966. | 84.6% of 39 patients |

Please see adjoining page for brief prescribing summary

TA-4919 PC

# THREE TIMES A YEAR

*Your patients without a plan to economically protect them when they are in need of medical assistance may join Hawaii's own community service medical plan on an individual basis three times a year.*

*Membership is open to qualified individuals of all ages in*

MARCH — JULY — *and* — NOVEMBER

*HMSA is a non-profit, community service organization. As such it is able to provide tremendous benefits for reasonably low dues.*

*HMSA is the medical plan which gives you free choice of doctors and hospitals — an extremely desirable feature.*

Member of Western Conference of Prepaid Medical Service Plans

HMSA

® BLUE SHIELD PLAN FOR HAWAII

## HAWAII MEDICAL SERVICE ASSOCIATION

*For More than 28 Years — Hawaii's Own / Hawaii Owned*

HMA delegates, the AMA Group Disability Insurance program, HMSA and plantation position statements, and the proposed Health Fair, Dr. Mills advised that General Victor Krulak, USMC, would be the guest speaker at the June meeting.

## Kauai

In the absence of the President, Dr. Wallis conducted the May 2 meeting. It was voted to allocate funds to the Woman's Auxiliary for the transaction of their business. The amount agreed upon was $2.00 a member. It was voted to drop Dr. Eichman from the Society's roster and hold up action on the status of Dr. Morris pending receipt of an answer from him. Dr. Wallis reported that HMA/HMSA negotiations had come to an impasse and advised that Honolulu County had sent out a bulletin on this subject. He also reported on the actions taken by the HMA Council at its April 21 meeting. Dr. Emrick reported on the HMA's plans to evaluate medical care in Hawaii. Dr. Kim advised that Dr. Hemmat would leave the island on May 19 and no psychiatrist replacement had been found. Approval was voted of the HMA project to make up a roster of retired physicians to determine if they could provide medical services. The HMA Delegate, Dr. Goodhue, asked for instructions. No specific instructions were given but recommendations were made and he was advised that the Society was in favor of the proposed HMA budget and dues increase.

* * *

At the June 4 meeting, HMA Delegate Dr. Goodhue reported on the actions taken by the House of Delegates the previous month. It was voted to continue supporting the HMA Careers Day program and pay a portion of each student's travel expenses. It was voted to invite Dr. Quisenberry to come to Kauai to discuss the role of the Utilization Committee. Approval was given to a list of proposed HMA committee appointments. It was voted to have each member contact his attorney and to send a letter to the Kauai Bar Society to determine if they are interested in establishing a liaison committee. No action was taken on a nonmember's newspaper account of the use of drugs by teenagers. Dr. Kim requested approval to hold the Diabetic Survey in October rather than November. Approval was given. Dr. Warner requested a transfer of membership to Hawaii County and resigned as Secretary-Treasurer. Dr. Albert C. Johnston was elected to succeed him.

## Maui

The only business discussed at the April 28 meeting was the filling out of forms requested by the Department of Health in connection with follow-up on the diabetic survey. It was decided that it was an imposition to ask the individual physicians to fill out the multiple forms. Dr. Juris Bergmanis presented the scientific portion. He discussed diagnostic and therapeutic neurosurgical problems with emphasis on patient observation.

* * *

The May 23 dinner meeting was held in Dr. Mark Sowers' home and the wives were invited. It was voted to accept the transfer of Dr. Robert Bjornson from the Ramsey County Medical Society. Rather than have a nurse from the State Department of Health attend a meeting to explain Medicare home care benefits, it was decided that she should call on the doctors individually or in groups. A change in the Bylaws was proposed which would make attendance at meetings compulsory. Drs. Sowers and Hanlon discussed at length the HMA Annual meeting and the proceedings of the House of Delegates. It was voted to thank Dr. Theodore Tomita for his many trips to Maui. ■

OXYGEN AIR-CONDITIONED

*24-HOUR SERVICE*

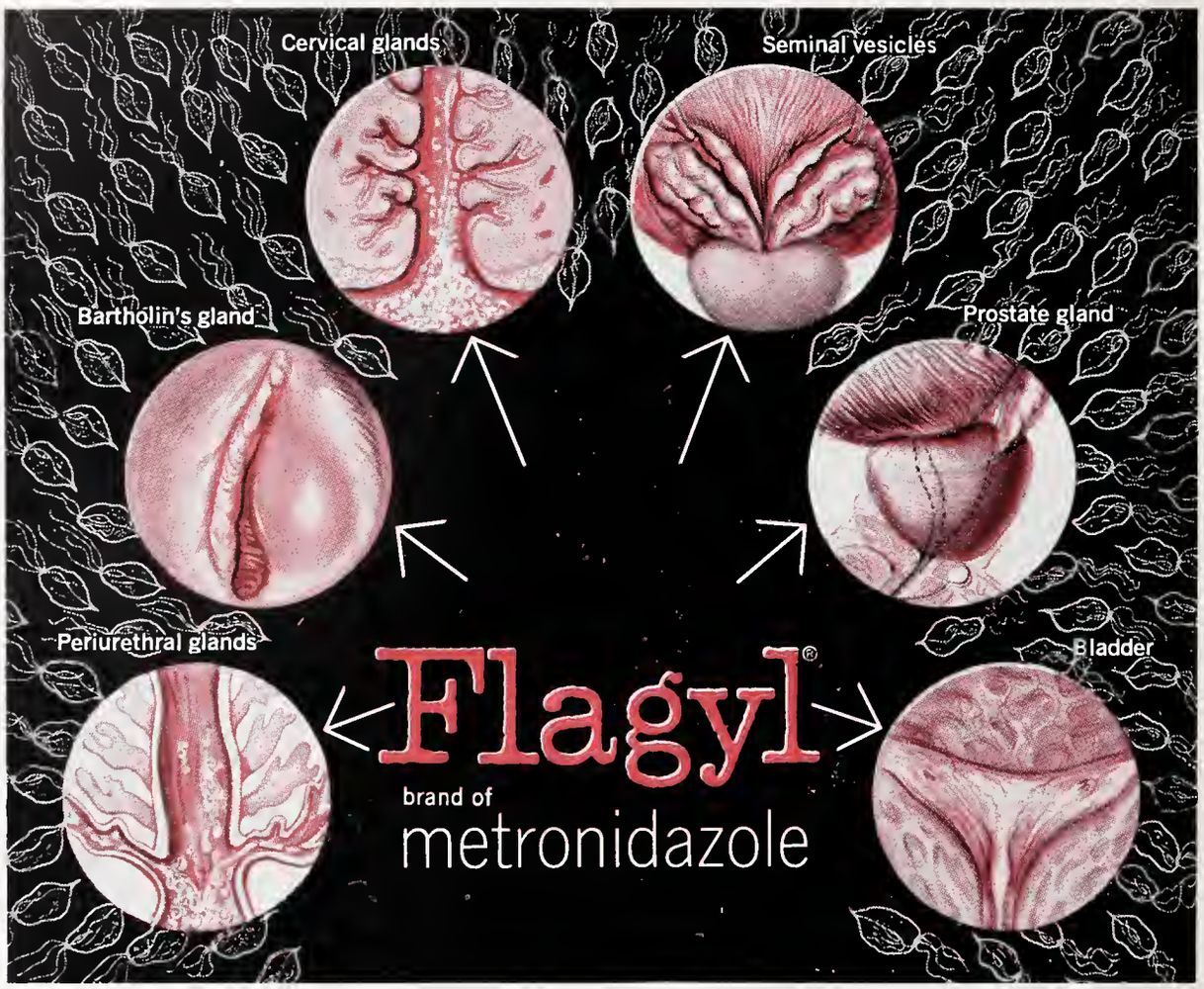
Physician's



**510-477**

**AMBULANCE SERVICE, INC.**

***Hawaii's Finest***




# Destroys Trichomonads Wherever They Are

**Flagyl** seeks out the sites where trichomonads hide. Only a systemic agent can. Only Flagyl does, selectively and effectively.

Flagyl destroys trichomonads in the inner crypts, glands and cavities of the genitourinary tract in both women and men. Consequently, Flagyl is capable not only of curing trichomoniasis in women but also of preventing reinfection.

Correctly used, with due attention to repeat courses of treatment for resistant, deep-seated invasion and to the presumption of reinfection from male consorts, Flagyl has repeatedly produced up to 100 per cent cure in large series of patients.

When the diagnosis of trichomoniasis is positive, Flagyl is positive.

*Dosage and Administration* — In *women:* one 250-mg. oral tablet three times daily for ten days. A vaginal insert of 500 mg. is available for local therapy when desired. When the inserts are used one vaginal insert should be placed high in the vaginal vault each day for ten days, and concurrently two oral tablets should be taken daily.

In *men* in whom trichomonads have been demonstrated: one 250-mg. oral tablet twice daily for ten days.

*Contraindications* — Pregnancy; disease of the central nervous system; evidence or history of blood dyscrasia.

*Precaution* — Complete blood cell counts should be made before, during and after therapy, especially if a second course is necessary.

*Side Effects* — Infrequent and minor side effects include nausea, metallic taste, furry tongue and headache. Other effects, all reported in an incidence of less than 1 per cent, are diarrhea, dizziness, vaginal dryness and burning, dry mouth, rash, urticaria, gastritis, drowsiness, insomnia, pruritus, sore tongue, darkened urine, anorexia, vomiting, epigastric distress, dysuria, depression, vertigo, incoordination, ataxia, abdominal cramping, constipation, stomatitis, numbness of an extremity, joint pains, confusion, irritability, weakness, flushing, cystitis, pelvic pressure, dyspareunia, fever, polyuria, incontinence, decreased libido, nasal congestion, proctitis and pyuria. Elimination of trichomonads may aggravate candidiasis.

*Dosage Forms*
Oral—250-mg. tablets. Vaginal—500-mg. inserts

SEARLE *Research in the Service of Medicine*

## *Notes and News* *continued from 558*

the **Lam Clinic.** In May, a thief broke into **Andy Ivy's** Kaneohe Bay Drive home, but was quickly apprehended. Also in May, **Wallace Loui's** Noela Drive home was broken into and robbed of $1,000 worth of jade and jewelry.

We noticed **Dan Palmer** looking unusually trim and learned that he had lost 35 lbs. When we pursued the matter and asked how he did it, our usually modest Dan smirked and replied with unabashed candor, "It's will power and lots of other fine qualities . . ."

## Conference Humor

Jocular pathologist **Paul Tamura** was discussing hepatomas at a Kuakini Surgical Conference. He showed figures which pointed toward a higher incidence of hepatomas among Orientals, especially the Koreans. But with some second thought, he cautioned, "Statistics are like women. They can be attractive; they all have figures; and for the right price, they may even lie for you. . . ."

At a Queen's CPC, a 62-year-old man with left chest pain was being discussed. The chest x-ray showed an obvious pneumothorax and the history and lab work-up pointed toward a myocardial rupture. The panelists all concurred in this presumptive diagnosis, but as pathologist **Ann Catts** rose slowly to explain the autopsy findings, a beatific smile reaching from cheek to cheek, **Fred Gilbert,** one of the panelists, paled and quipped, "I am always concerned about a pathologist with a broad smile after a dissertation. . . ." Sure enough, Ann reported that there was no pneumothorax and no myocardial rupture. Sometimes, we all feel that with pathologists, who needs a hole in the head?

At yet another Queen's conference, the following repartee was overhead after the discussion of a 60-year-old Caucasian man who had died of bronchogenic Ca: Resident **Phil Jones** first looked around carefully to see that anti-smoking proponent **Mort Berk** was absent, then boldly commented, "The answer is not to stop smoking, but to remove the carcinogens from cigarettes." Middle-of-the-roader **Fred Gilbert** retorted, "I beg to differ. We should hold off smoking till the carcinogens are removed, *then* resume. . . ." ■

## *Book Reviews* *continued from 554*

(whether or not he realizes it) in his psychotherapeutic work. In addition it will also enhance his understanding of what happens in his own doctor-patient relationships.

WALTER F. CHAR, M.D.

### ★ Textbook of Radiotherapy

*By Gilbert H. Fletcher, M.D., 580 pp., $20.00, Lea & Febiger, 1966.*

RADIATION THERAPY has advanced in theory and practice to such a degree that a student specializing in the field or in any of the associated surgical fields for cancer needs a textbook or manual such as this for his training.

For him, this book is complete in basic theory and practice. It answers the many questions and doubts that rise so frequently before him. The references are adequately covered.

The practicing radiation therapist who has kept up with the latest developments will find the methods and results up-to-date and comprehensible.

Two interesting developments are noted. First, the term "kilovoltage" was only mentioned in the preface. Supervoltage technique (2 megavolts and up, and 60

*continued page 622*


WHEN YOU HAVE
A CALL TO MAKE
...CALL HAWAIIAN AIRLINES
FOR CONVENIENT JET FLIGHTS
TO ALL ISLANDS
WHETHER FOR
BUSINESS OR PLEASURE

FOR RESERVATIONS CALL:

| | | |
|---|---|---|
| HONOLULU | KAHULUI | LANAI |
| 817-611 | 75-011 | 3-222 |
| HANA | KAMUELA | LIHUE |
| 442-483 | 858-505 | 2-751 |
| HILO | KONA | MOLOKAI |
| 50-811 | 256-465 | 37-475 |

HAWAIIAN AIRLINES
Holder of the World's Safety Record





These glasses are important to him—in his work, socially, and in terms of his physical well-being.

When's the last time you had an eye check? Schedule an appointment soon with your eye physician.

OBRIG Contact Lenses fitted by prescription. We are GUILD OPTICIANS, serving Hawaii since 1939.

OPTICAL DISPENSERS
of Hawaii, Inc.

| | |
|---|---|
| 1133 BISHOP ST. | 576-570 |
| 312 ALA MOANA BLDG. | 976-925 |
| PROFESSIONAL CENTER BLDG., KAILUA | 256-030 |

Cobalt) have been found to be far more satisfactory for both doctor and patient. Secondly is the concept of a radiation therapist whose total training and work should complement those of several surgical and gynecological fields.

JUN-CHUAN WANG, M.D.

### ★ The Medical Lexicographer

*By J. E. Schmidt, M.D., 105 pp., $4.75. Charles C. Thomas, 1966.*

IF THERE IS A WORD for what you're thinking of, Dr. Schmidt will tell you what it is; if there isn't one, he'll invent it from Greek or Latin roots, whether there's a better word already available in English or not. No permissive lexicographer, he roundly denounces the spelling of orthopedics with the "ae" ligature (which he calls a diphthong). The disappearance of the "a" and "o" from ae and oe should indeed be encouraged; it seems to make little or no difference in most words, though it has gotten Americans to pronouncing *oestrus* and *stilboestrol* "ĕstrus" and "stilbĕstrol"—which seems to have done no damage.

Did you know that *egophony* meant "goat's voice"? But sometimes Dr. Schmidt reaches far afield; asked for a word meaning "toothlessness," he passes up *edentulism* completely and suggests *agomphiasis*. It will never sell!

No one interested in words can afford not to have this slim volume (the index has over 1,000 entries!) as a companion to his dictionaries.

HARRY L. ARNOLD, JR., M.D.

### World Eradication of Infectious Diseases

*By E. Harold Hinman, Ph.D., M.P.H., M.D., F.A.C.P., F.I.C.S., (Hon.), 223 pp., $8.50, Charles C. Thomas, 1966.*

THIS 203-PAGE BOOK begins with a brief historical review of the great epidemics which affected man as he began to crowd the earth. More space is devoted to malaria due to its importance, a longer period of experience with control measures, and good progress toward global eradication.

Other diseases with chapter-length reviews from the viewpoint of eradication are yellow fever, smallpox, yaws, and tuberculosis. Brief comments are included on polio, measles, trachoma, pinta, typhus, plague, and the common intestinal parasites. [But not leprosy?—ED.]

The material is public-health oriented and of primary value to publiic-health administrators, engineers, sanitarians, entomologists, and epidemiologists, but of interest to general practitioners and pediatricians by providing background information for some of the diseases against which immunizations are maintained for either residents or travelers. The world eradication of communicable disease is a concept adopted by the World Health Organization, and we may expect our own government to be drawn deeper into the financial support of disease eradication programs in the underdeveloped parts of the world in the years ahead. This book will help you understand the goals and principles which form the basis for increasing support by our government.

IRA HIRSCHY, M.D

### Synopsis of Dermatology

*By William D. Stewart, M.D., F.R.C.P. (C), Julius L. Danto, M.D., and Stuart Maddin, M.D., 664 pp., $10.85, The C. V. Mosby Company, 1966.*

THE INFORMATION CONTAINED in this compact volume and the mode of presentation are designed to afford the physician diagnostic clues which the authors hope will prove helpful in clinical practice. It may also inspire the reader to search for pertinent literature or for a comprehensive review of a particular skin disease. This book is not so much a compendium of existing literature, but represents in most instances as far as therapy is concerned, the experience of the authors. It is up to date in every phase of dermatology.

The colored photographs, even the black and white pictures, are the best this reviewer has ever seen in print. Each disease is clearly presented and the fundamental morphology is demonstrated accurately.

The author states that this book is for the nondermatologist who wishes definite information, methods of diagnosis and treatment of common and some of the uncommon skin diseases. This will be an ideal compendium for the intern, resident, and general practitioner.

HAROLD M. JOHNSON, M.D.

### ★ Recent Advances in Nuclear Medicine

*Edited by Millard N. Croll, M.D., and Luther W. Brady, M.D., 260 pp., $12.50, Appleton-Century-Crofts, 1966.*

THIS SYMPOSIUM DEALS with many of the recent advances in nuclear medicine and includes discussions on instrumentation, dynamic function studies, radiopharmaceuticals and dosimetry, and organ scanning. The text contains many articles of clinical significance but is especially recommended for those with specific interest in nuclear medicine. Although it is not a reference text for nuclear medicine in general, the practicing clinician will find articles of interest, particularly in the organ-scanning section. The editors are to be congratulated on this valuable text.

WINFRED Y. LEE, M.D.

### Dizziness and Vertigo: Diagnosis and Treatment

*Edited by Martin Spector, M.D., 299 pp., $17.75, Grune & Stratton, 1967.*

CONTRIBUTORS FROM the various fields of otolaryngology, neurosurgery, neurology, internal medicine, radiology,



BLEMISHES?

COVERMARK conceals all skin discolorations . . . birthmarks, brown & white patches, broken veins, tattoos, burns, scars, on any part of the body. COVERMARK is also unexcelled as an overall makeup . . . will not rub or flake off. Waterproof and Sunproof.

Lydia O'Leary
OF HAWAII
ALA MOANA CENTER—STREET LEVEL
PHONE 993-288

ophthalmology, psychiatry, etc., make a serious attempt to compile in one book a comprehensive approach to the frequently perplexing problem of dizziness and vertigo. The book is wisely divided into four sections: (1) anatomy and physiology, history and examination; (2) clinical syndromes of otologic origin; (3) clinical syndromes of nonotologic origin; (4) treatment. It discusses newer methods of examination, testing, and therapeutics. It undoubtedly reflects the prejudices of each contributor, but is recommended reading and a source of reference which includes a fairly comprehensive bibliography.

GEORGE KIMATA, M.D.

### ★ The Treatment of Fractures

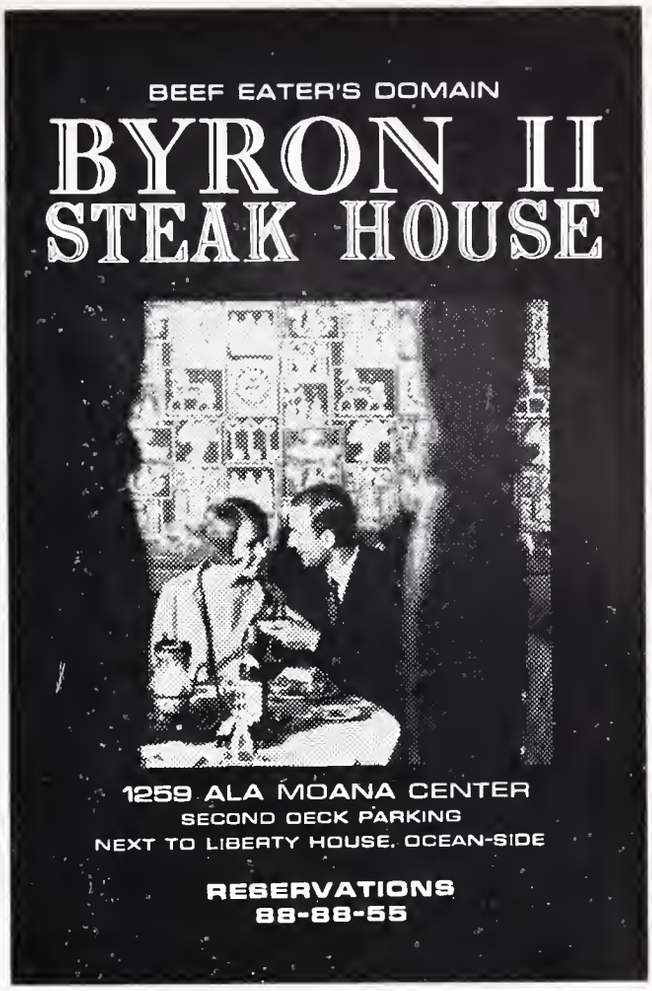
*By Lorenz Böhler, M.D., 400 pp., $28.75, Grune & Stratton, 1966.*

THIS 390-PAGE BOOK supplements and corrects the 2,300 page fifth edition of Lorenz Böhler's tome on the treatment of fractures. It is an excellent work, well worth reading even if one has never seen the original 2,300-page giant.

Although dealing primarily with fractures, the book is designed for the trauma surgeon and includes many aspects not usually covered in the standard text. Included are a section on the treatment of acute arterial injuries and an excellent section on the diagnosis and treatment of skull and intracranial injuries. The chapter dealing with the evaluation of brain concussions is especially germane for any one who deals with the "multiple injury patient" seen so often following high speed automobile accidents.

The style shows a certain Teutonic rigidity. Discussion of fracture treatment includes the exact amount of padding and number of rolls of plaster to be used on each cast, according to Doctor Böhler. However, this

*continued page 627*


*MEDICAL SPACE AVAILABLE*




**WAIALAE OFFICE CENTER**

LOCATED IN WAIALAE SHOPPING CENTER

Just Completed • Air Conditioned • Free Parking

Serving 125,000 People in the Kaimuki-Waialae Trade Area

***Also space available in:***

**PEARL CITY SHOPPING CENTER AND NIU VALLEY SHOPPING CENTER**

**HAWAII SHOPPING CENTER CORPORATION**

**PHONE 773-992 • 770-848**

# Against these three major pathogens…



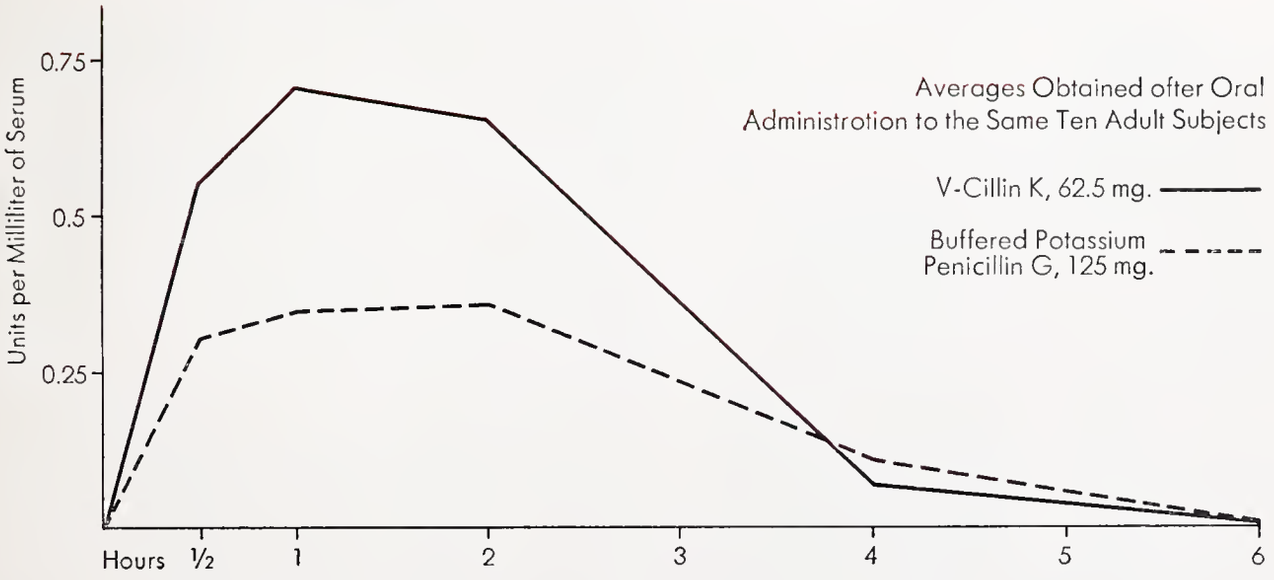
# V-Cillin K® provides dependable oral antibacterial activity

## because it combines a high degree of in-vitro activity...

| Antibiotic | Staph. Aureus (Penicillin-Sensitive) MIC (mcg./ml.) Median | Range | Streptococcus, Group A MIC (mcg./ml.) Median | Range | Diplococcus Pneumoniae MIC (mcg./ml.) Median | Range |
|---|---|---|---|---|---|---|
| Penicillin V | 0.02 | 0.02-0.04 | 0.02 | 0.003-0.4 | 0.01 | 0.005-0.2 |
| Penicillin G | 0.02 | 0.005-1.6 | 0.005 | 0.002-0.2 | 0.02 | 0.01-0.1 |
| Methicillin | 1.6 | 0.4-6.3 | 0.2 | 0.1-0.4 | 0.2 | 0.1-1.6 |
| Oxacillin | 0.4 | 0.1-3.1 | 0.04 | 0.02-0.4 | 0.1 | 0.04-0.8 |
| Cloxocillin | 0.2 | 0.2-0.8 | 0.1 | 0.1-0.8 | — | — |
| Nofcillin | 0.4 | 0.2-0.8 | 0.04 | 0.02-0.1 | 0.02 | 0.02-0.2 |
| Ampicillin | 0.2 | 0.1-0.8 | 0.02 | 0.01-0.04 | 0.02 | 0.01-0.04 |

Adapted from Klein, J. O., and Finland, M.. New England J. Med ,269:1019, 1963.

## with high blood levels, even in the presence of food




Adapted from Griffith, R. S., and Black, H. R.: Current Ther. Res., 6 253, 1964.

**V-Cillin K®** Lilly 700867

**Potassium Phenoxymethyl Penicillin**

*(See next page for prescribing information.)*

# New 500 mg. tablets...a more convenient way to give high doses




**Description:** V-Cillin K is the potassium salt of V-Cillin® (phenoxymethyl penicillin, Lilly). This chemically improved form combines acid stability with immediate solubility and rapid absorption. Higher serum levels are obtained more rapidly with this penicillin than with equal oral doses of penicillin G. The higher serum levels and acid stability of V-Cillin K make it a more dependable penicillin for oral use.

V-Cillin K, Pediatric, is an oral solution of clinically proved V-Cillin K in teaspoon dosage form. When mixed as directed, each 5 cc. (approximately one teaspoonful) will contain 125 mg. (200,000 units) phenoxymethyl penicillin as the potassium salt.

**Indications:** V-Cillin K has been shown to be effective in the treatment of streptococcus, pneumococcus, and gonococcus infections as well as infections caused by sensitive strains of staphylococci. It may be used for the prophylaxis of streptococcus infections in patients with a history of rheumatic fever and for the prevention of bacterial endocarditis after tonsillectomy and tooth extraction in those patients with a history of rheumatic fever or congenital heart disease.

**Contraindication:** V-Cillin K should not be administered to a patient with a history of penicillin hypersensitivity.

**Warnings:** In rare instances, the use of penicillin may cause acute anaphylaxis which may prove fatal unless promptly controlled. This type of reaction appears more frequently in patients with a history of sensitivity reactions to penicillin and in those with bronchial asthma or other allergies. Resuscitative drugs should be readily available for emergency administration. These include epinephrine and pressor drugs (as well as oxygen for inhalation) for relief of immediate allergic manifestations and antihistamines and corticosteroids for delayed effects.

**Precautions:** V-Cillin K should be used cautiously, if at all, in a patient with a strongly positive history of allergy.

In prolonged therapy with penicillin, and particularly with high parenteral dosage schedules, frequent evaluation of the renal and hematopoietic systems is recommended.

In suspected staphylococcus infections, proper laboratory studies (including sensitivity tests) should be performed.

The use of penicillin may be associated with the overgrowth of pencillin-insensitive organisms. In such cases, its administration should be discontinued, and appropriate measures should be taken.

**Adverse Reactions:** Although serious allergic reactions are much less common with administration of oral penicillin than with intramuscular forms, manifestations of penicillin allergy may occur.

Penicillin is a substance of low toxicity, but it does possess a significant index of sensitization. The following hypersensitivity reactions associated with the use of penicillin have been reported: skin rashes ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; and reactions resembling serum sickness, including chills, fever, edema, arthralgia, and prostration. Severe and often fatal anaphylaxis has occurred (see Warnings). Hemolytic anemia, leukopenia, thrombocytopenia, and nephropathy are rarely observed side-effects and are usually associated with high parenteral dosage.

**Administration and Dosage:** For Tablets V-Cillin K and for V-Cillin K, Pediatric, the usual dosage ranges from 125 mg. (200,000 units) three times a day to 500 mg. (800,000 units) every four hours. For infants, the daily dosage may be 50 mg. per Kg. of body weight divided into three doses.

Beta-hemolytic streptococcus infections without associated bacteremia may be treated with 200,000 to 400,0000 units three times a day. Therapy should be continued for a minimum of ten days to prevent development of rheumatic fever and/or other serious complications. Dosage for routine streptococcus prophylaxis in patients with a history of rheumatic fever or congenital heart disease may be 200,000 units once or twice daily. When such patients undergo tonsillectomy, tooth extraction, or other minor surgery, the prophylactic dose should be 500,000 units every six hours given two days prior to surgery and for two days postoperatively. If oral medication is not feasible on the day of surgery, parenteral therapy should be considered. Mild to moderately severe pneumococcus pneumonia has been treated effectively with 250 mg. every six hours.

In staphylococcus infections, 400,000 units or more should be given every six to eight hours in conjunction with indicated surgical procedures.

For gonorrhea in males, 500 mg. (800,000 units) every four hours for three doses may be employed; in females, 500 mg. every four hours for six doses are recommended. Refractory infections generally respond to a second treatment three to four days following completion of the first. Treatment of gonorrhea with severe complications should be individualized, with prolonged and intensive treatment. Patients with a suspected lesion of syphilis should have a dark-field examination before receiving penicillin and monthly serologic tests for a minimum of three months.

**How Supplied:** Tablets V-Cillin K, U.S.P., 125 mg. (200,000 units), in bottles of 50 and 100; and 250 mg. (400,0000 units) and 500 mg. (800,000 units), in bottles of 24 and 100.

V-Cillin K, Pediatric, for Oral Solution, 125 mg. (200,000 units) per 5 cc. of solution, in 40, 80, and 150-cc.-size packages. [032067]

*Additional information available to physicians upon request. Eli Lilly and Company, Indianapolis, Indiana 46206.*

Lilly

700867

didactic approach, coupled with a detailed table of contents, makes the book valuable as a reference text on fracture treatment.

Professor Böhler begins and ends his text with this classic admonition to the fracture surgeon, "Not only should distraction of fracture fragments be avoided, but some shortening should be produced to facilitate the fracture's healing."

ALAN PAVEL, M.D.

### ★ Human Development

*Edited by Frank Falkner, M.D., M.R.C.P., 644 pp., $20.00, W. B. Saunders Company, 1966.*

AT FIRST GLANCE this book is too large, but when one scans the pages, he soon realizes the enormity of the project: the relative conciseness is soon appreciated.

It is refreshing to find this compendium an international product of contributing authors.

The section on the endocrinological effect on development is, by necessity, abbreviated and lacking; yet considerable newness of thought and values can be found therein.

Over 100 pages are devoted to the psychological growth of a child including the popular theme of learning abilities and disabilities.

The chapter on statistical analysis apparently is included for completeness.

There is an excellent section on neonatal neurological development, replete with photographs, as is the entire volume.

The chapter on perinatal adaptive measures and development, especially the section dealing with early pulmonary requirements is outstanding.

There is a handy photographic embryological timetable at the back of the book.

R. G. DIMLER, M.D.

### ★★ Disorders of the Respiratory Tract in Children

*Edited by Edwin L. Kendig, Jr., M.D., 834 pp., $26.00, W. B. Saunders, 1967.*

PHYSICIANS WITH A special interest in respiratory disorders in children have long needed a definitive text encompassing in one volume the kind of information available to other subspecialists. At long last such a comprehensive volume has been prepared; Dr. E. L. Kendig, Jr. has edited a text to truly fill the need. The writing is generally of high quality, the information is current and very well organized, and the field has been covered in admirable detail.

We have a compendium of respiratory diseases from the nose and ear on down, including a special section dealing with the newborn, and a most valuable section on "other diseases with a prominent respiratory component." The introductory chapter on basic physiology is rather taxing reading for the clinician, but is well worth the effort. Of special value is the chapter on procedures by Dr. Waring, and of special excellence is the comprehensive concise review of cystic fibrosis by Dr. Schwachman. Uncommon entities are adequately covered, while appropriate emphasis is given to the commoner major diseases.

Technically, this book is also outstanding, with many unusually clear x-ray reproductions and well-chosen

*continued page 628*

Your stationery is a reflection of you... be certain the reflection is good!

*star-bulletin printing company*

*the hallmark of fine printing in honolulu*




BOTTLED UNDER AUTHORITY OF THE COCA-COLA COMPANY BY COCA-COLA BOTTLING COMPANY OF HONOLULU, INC.

*Presidential Address* continued from 530

will continue to be, investigated by the House of Representatives.

In the meantime, unless HMSA is willing to meet the demands as set forth by the House of Delegates, I hope we will stand united so as not to lose another prerogative of the physician. We should review and police our own acts and members and not permit a third party to do it.

Because we in the medical profession believe that the people of Hawaii want more comprehensive medical care which is predictable in cost, we had an enabling act introduced in the last session. It never came out of the Senate committee. This bill would have permitted physicians to co-insure a health insurance program and guarantee the success of such an endeavor. In spite of this failure, I am still convinced that we should embark immediately in negotiations with State and City and County officials to offer a doctor-sponsored, comprehensive, predictable plan for their employees.

CLOSING REMARKS

The sweeping national medical legislation that our social planners have imposed upon the American people has had and will have a profound effect on the medical profession. The Federal government already has the authority to take care of the health needs of every man, woman, and child in this country under Titles XVIII and XIX, without further amendments to the laws. The planners would have you believe that all the ills can be cured by bureaucratic decision making.

As Dr. Ernest B. Chain, Nobel Prize winner and English biochemist, said "The more political influence we permit in the field of medicine, the more surely we will sacrifice individual excellence for mass mediocrity."

To prevent further encroachment of individual rights and liberty, we must not compromise principles and we must fight to preserve our professional freedom. We must fight indifference—for through indifference, freedom is eventually lost and destroyed.

We must become more knowledgeable in socio-economic and political affairs, and actively participate in all the affairs of our community and government when health and medical care are involved. We can no longer afford to leave legislation to the legislators, economics to the economists, and planning to public and private agencies.

Ignorance and indifference in these areas will guarantee that the patterns of future medical care and practice will be shaped largely without the doctors' contributions.

If this happens, both the doctors and the patients will be losers.

The hour before dawn is the darkest, but we must remain united in strength to seize the initiative to preserve individual freedom so as not to fail those who preceded us or those who will come after us.

I am grateful to all the members of HMA for the privilege of having served you as your President. The experience has enriched me, and I leave you a cherished portion of my life and everlasting gratefulness. ■

94-801 Farrington Hwy.

*Book Reviews* continued from 627

illustrations of high quality. The diagrams of bronchial segments and positions for their drainage are especially valuable. Few typographical errors are seen, although one involves an entire graph turned upside-down (Fig. 64-2). At the chapter ends current bibliographies are generally carefully chosen, but vary markedly in completeness and organization.

All physicians dealing with children will want access to this major textbook. It is most highly recommended.

JOSEPH OREN, M.D.

### ★ Progress in Hematology, Vol. 5

*Edited by Elmer B. Brown, M.D., and Carl V. Moore, M.D., 399 pp., $16.75, Grune & Stratton, 1966.*

TWENTY-ONE contributors have made important and extensive reviews of subjects in various specialized areas related to hematology in an up to date and authoritative manner. Not all phases of hematology are covered in this volume, but only certain subjects which the authors

*continued page 631*

FREE DELIVERY

CHARGE PRIVILEGES

*Our Pills and Potions Are the Best of the Best*
*Our Prescription Service Has Stood the Time Test*

SUMMERS PRESCRIPTION SHOPS

349 YOUNG BLDG.
576-378

416 ALA MOANA BLDG.
941-9021




# Geigy...a proud addition to the AMFAC line

Anturane® tab.
Butazolidin® tab.
Butazolidin® alka cap.
Dulcolax® tab.
Dulcolax® supp.
Eurax® Cream
Eurax® Lotion
Hygroton® tab.
Medomin® tab.
Persantine® tab.
Pertofrane® cap.
Preludin® tab.
Preludin® endurets
Prelu-Vite® cap.
Regroton® tab.
Sintrom® tab.
Sterazolidin® cap.
Sterosan® Cream
Sterosan® Ointment
Sterosan® — hydrocortisone Cream
Sterosan® — hydrocortisone Ointment
Tandearil® tab.
Tofrānil® tab.
Tofrānil® amp.
Tromexan® tab.

## AMFAC INC DRUG DEPARTMENT

**Phone 585-531** for same day delivery and scheduled rural delivery



Prescribe a good night's sleep for your cardiac patients with insomnia

Prescribe
# Doriden
(glutethimide)

- Sleep comes gently, usually within 15 to 30 minutes; preexcitation rarely a problem.
- Patients generally awake refreshed; morning "hangover" an exception
- Rarely, if ever, causes respiratory depression in recommended dosage
- Well tolerated, even by the aged and chronically ill
- Adverse effects on liver and kidney not anticipated

Please see following page for prescribing information.



# Doriden®
## (glutethimide CIBA)

**Indications and Dosage:** *Insomnia*–0.5 Gm at bedtime. *Preoperative Sedation* –0.5 Gm the night before surgery; 0.5 to 1 Gm one hour before anesthesia. *Obstetric Sedation*—0.5 Gm at onset of labor.

Continuing total daily dosage over 1 Gm is not recommended. In presence of pain, not recommended alone.

**Caution:** Supervise dosage carefully, especially in patients with a known propensity for overdosing. Excessive and prolonged use in susceptible persons (*e.g.*, alcoholics, former addicts, severe psychoneurotics) may result in dependence and withdrawal reactions. In those cases, reduce dosage gradually to lessen the likelihood of withdrawal reactions such as nausea, abdominal discomfort, tremors, or convulsions. Newborns of mothers dependent on glutethimide may exhibit withdrawal symptoms.

**Side Effects:** Occasionally a skin rash may occur; if so, withdraw drug. The rash usually clears spontaneously in 2 or 3 days. Occasionally nausea also occurs. Rarely, acute hypersensitivity reactions and blood dyscrasias have been associated with glutethimide therapy.

**Supplied:** *Tablets,* 0.5 Gm (white, scored) and 0.25 Gm (white, scored); bottles of 100, 500 and 1000. *Tablets,* 0.125 Gm (white); bottles of 100. *Capsules,* 0.5 Gm (blue and white); bottles of 100.

*Consult complete literature before prescribing.*

CIBA Pharmaceutical Company
Summit, N.J.

C I B A

2/3609E

*Book Reviews continued from 628*

feel are not adequately covered or are controversial. The contributors are all experts in their fields of review. The book is recommended to all hematologists and to any one else interested in the progress and current status of certain specific subjects in the highly complex field of hematology.

ROBERT T. S. JIM, M.D.

### Hematologic Problems in the Newborn

*By Frank A. Oski, M.D., and J. Lawrence Naiman, M.D., 294 pp., $11.00, W. B. Saunders Company, 1966.*

HEMATOLOGIC INTERACTIONS in the neonatal period are a particularly fascinating facet of hematology. In no other period of life do physiologic changes occur so rapidly, or are so profoundly affected by a concurrent pathologic process. The challenging problems confronted in this immediate postuterine period of life are presented with thoroughness and clarity in this monograph. Especially excellent is their treatment of maternal-fetal relationships and erythroblastosis fetalis. The problems of bleeding, jaundice, and anemia in the neonatal period are viewed through a clinical, diagnostic approach and the text is interspersed with simplifying diagrams. This volume will be helpful to pediatricians, general practitioners, and obstetricians.

REGINALD HO, M.D.

## Also Received

### The Specificity of Cell Surfaces

*Editors Bernard D. Davis and Leonard Warren, 290 pp., $10.25, Prentice-Hall, Inc. 1967.*

A VERY technical text on recent advances in this aspect of molecular biology.

### Cancer Chemotherapy (The Fifteenth Hahnemann Symposium)

*Editors Isadore Brodsky, M.D., and S. Benham Kahn, M.D., 348 pp., $18.50 Grune & Stratton, 1967.*

ANOTHER EXCELLENT Hahnemann symposium, comprehensive and authoritative.

### ★ Clinical Pathology: Interpretation and Application

*By Benjamin B. Wells, M.D., Ph.D., and James A. Halsted, M.D., 708 pp., $11.50, W. B. Saunders, 1967.*

THIS TEXT IS well illustrated and clearly written and should serve as an excellent reference for those interested in fully understanding the laboratory test in terms of clinical problems.

### ★ Diabetes for Diabetics: A Practical Guide

*By George F. Schmitt, M.D., F.A.C.P., 237 pp., $5.95, The Diabetes Press, 1965.*

THIS MANUAL of diabetes presents the problems of diabetes in a concise manner and is well illustrated and arranged. This is especially recommended for the educated and interested diabetic who desires a fuller understanding of his disorder.

### Strabismus: A Programmed Text

*By Robert D. Reinecke, M.D., and David Miller, M.D., 315 pp., $14.50, Appleton-Century-Crofts, 1966.*

ANOTHER EXCELLENT programmed text on an important subject.

*continued page 636*

# Sick, and worried sick



Professionally posed



Anxiety and tension stemming from organic illness may undermine your patient's cooperation and possibly retard success of primary therapy.

If his emotional symptoms persist in the face of your counsel and reassurance, you may want to consider adjunctive use of SERAX (oxazepam). It is indicated in anxiety, tension, agitation, irritability, and anxiety associated with depression. May be used in a broad range of patients, usually with considerable dosage flexibility.

When prescribing, carefully observe dosage recommendations and appropriate precautions, especially as pertaining to the elderly and when complications could ensue from a fall in blood pressure. (See Wyeth literature or PDR as well as "IN BRIEF" below.)

**IN BRIEF.**

**Contraindications:** History of previous hypersensitivity to oxazepam. Oxazepam is not indicated in psychoses.

**Precautions:** Hypotensive reactions are rare, but use with caution where complications could ensue from a fall in blood pressure, especially in the elderly. Withdrawal symptoms upon discontinuation have been noted in some patients exhibiting drug dependence through chronic overdose. Carefully supervise dose and amounts prescribed, especially for patients prone to overdose; excessive, prolonged use in susceptible patients (alcoholics, ex-addicts, etc.) may result in dependence or habituation. Reduce dosage gradually after prolonged excessive dosage to avoid possible epileptiform seizures. Withdrawal symptoms following abrupt discontinuance are similar to those seen with barbiturates. Caution patients against driving or operating machinery until absence of drowsiness or dizziness is ascertained. Warn patients of possible reduction in alcohol tolerance. Safety for use in pregnancy has not been established.

Not indicated in children under 6 years; absolute dosage for 6- to 12-year-olds not established.

**Side Effects:** Therapy-interrupting side effects are rare. Transient mild drowsiness is common initially; if persistent, reduce dosage. Dizziness, vertigo and headache have also occurred infrequently; syncope, rarely. Mild paradoxical reactions (excitement, stimulation of affect) are reported in psychiatric patients. Minor diffuse rashes (morbilliform, urticarial and maculopapular) are rare. Nausea, lethargy, edema, slurred speech, tremor and altered libido are rare and generally controllable by dosage reduction. Although rare, leucopenia and hepatic dysfunction including jaundice have been reported during therapy. Periodic blood counts and liver function tests are advised. Ataxia, reported rarely, does not appear related to dose or age. These side reactions, noted with related compounds, are not yet reported: paradoxical excitation with severe rage reactions, hallucinations, menstrual irregularities, change in EEG pattern, blood dyscrasias (including agranulocytosis), blurred vision, diplopia, incontinence, stupor, disorientation, fever and euphoria.

**Availability:** Capsules of 10,15 and 30 mg. oxazepam.

**To help you relieve anxiety and tension**

# Serax® (oxazepam)

Wyeth® SERVICE TO MEDICINE

Wyeth Laboratories
Philadelphia, Pa.

# INDEX TO VOLUME 26

## Subject and Title Index


### A

Acculturation, and food choice, among some ethnic groups ..... 209
Admissions, first, to the Hawaii State Hospital..... 207
American Cancer Society, 1966 scientific session, special report..... 213
Aneurysm, aortic, primary aortoduodenal fistula due to rupture of..... 423
Antibiotic era, intracrania complications of otitis media in this: report of cases..... 426
Aortic aneurysm, primary aortoduodenal fistula due to rupture of..... 423
Aorta, thoracic, deceleration of the..... 312
Arnold, Jr., Harry Loren, tribute to, on the 25th anniversary of the HAWAII MEDICAL JOURNAL 1941-1966..... 25
Artery, femoropopliteac: reconstruction..... 435
Kinking, internal carotid..... 416

### B

Book reviews .....45, 133, 228, 322, 443, 554

### C

Carcinoma of the conjunctiva..... 430
Carotid, artery kinking, internal..... 416
Childhood leukemia in Hawaii experience at Kauikeolani Children's Hospital..... 125
China, early fertility—management concepts in..... 110
Complete vascular ring as a cause of esophageal and tracheal compression: review of the literature and report of a case..... 412
Conjunctiva, carcinoma of the..... 430
Conversion, fixed, vs. customary fees, the relative value studies..... 115
Correspondence .....7, 142
County Society Reports.....48,135, 227, 325, 444, 556
Cystadeno fibroma of the ovary: report of a case..... 409

### D

Deceleration injury of the thoracic aorta..... 312
Dermatology, progress in..... 34
Diarrheas, acute, of infancy and childhood, early differential diagnosis and specific treatment in the..... 303
Differential mortality in Honolulu before 1900..... 537

### E

Early differential diagnosis and specific treatment in the acute diarrheas of infancy and childhood 303
Editorials
A little wine, for thy stomach's sake..... 319
*Aloha oiaio,* Leo Bernstein..... 219
Dietitians and the medical team..... 439
Foundation for Medical Care..... 128
Generic equivalence ..... 549
Home care program..... 439
Looking for lost IUD's..... 129
Medic alert saves lives..... 550
Planning for future medical care..... 402
Privileges ..... 318
Reppunzel, Reppunzel, put up your hair..... 39
St. Francis Hospital takes a bow..... 401
The Aloha United Fund—a preliminary report.... 129
The autumn of our sorrowful discontent..... 219
The declaration of Helsinki..... 40
The political credo of a physician..... 41
Typhoid—remembrance of things past..... 40
Esophageal and tracheal compression, complete vascular ring as a cause of: review of the literature and report of a case..... 412
Ethnic groups, food choice and acculturation among some ..... 209

### F

Fees, customary vs. fixed conversion, the relative value studies..... 115
Femoropopliteal artery reconstruction..... 435
Fertility, early—management concepts in China..... 110
First admissions to Hawaii State Hospital..... 207
First National Congress on the socio-economics of health care: report..... 543
Fistula, primary aortoduodenal, due to rupture of aortic aneurysm..... 423
Fixed conversion vs. customary fees, the relative value studies..... 115
Food choice and acculturation among some ethnic groups ..... 209

### H

Hand tumors: a review..... 403
Hawaii Academy of General Practice .....42, 130, 223, 323, 440, 553
Hawaii
Childhood leukemia in, experience at Kauikeolani Children's Hospital..... 125
Hepatoma: A clinical and pathogenic study of cases occurring during 1930-1959 in..... 418
Medical Association .....138, 325, 445, 560
MEDICAL JOURNAL—1941-1966, tribute to Harry Loren Arnold, Jr., on the 25th anniversary of the..... 25
Multiple myeloma and macoroglobulinemia cases in ..... 531
State Hospital,
First admissions to..... 207
Ten year profile of, a statistical analysis..... 201
Surgical advances in, during the past 25 years..... 35
Technologists Bulletin .....52, 140, 232, 330, 458, 614
Hepatoma: a clinical and pathologic study of cases occurring during 1950-1959 in Hawaii.... 418
Honolulu, differential mortality in, before 1900..... 537

### I

Immunogenic studies on mongolism..... 121
Infancy and childhood, early differential diagnosis and specific treatment in the acute diarrheas of.. 303
Intracranial complications of otitis media in this antibiotic era: report of cases..... 426
Internal carotid artery kinking..... 416
In Memoriam—Doctors of Hawaii .....44, 132, 222, 320, 442
Allen, Frederick Emerson..... 132
Barton, Charles ..... 132
Blake, Charles Robert..... 222
Bliss, George Stephen..... 44
Crane, Augustin Averill..... 552
Kuehn, Rolando ..... 552
Laidlaw, Horace D..... 222
Mjedloff, Peter Alexander..... 442
Osorio, Vasco Eric Montier..... 44
Reppun, Carl Frederick..... 320

### L

Leukemia, childhood, in Hawaii, experience at Kauikeolani Children's Hospital..... 125

## M

Macroglobulinemia and multiple myeloma cases in Hawaii ..... 531
Medulloblastoma: a case report ..... 432
Mongolism, immunogenic studies on ..... 121
Mortality, differential, in Honolulu before 1900 .....
Multiple myeloma and macroglobulinemia cases in Hawaii ..... 531
Mycobacterioses: The case against tradition ..... 301
Myleloma, multiple, and macroglobulinemia cases in Hawaii ..... 531

## N

New Members ..... 48, 134, 226, 324, 444, 556
Notes and News ..... 46, 136, 224, 326, 446, 557

## O

Obituaries
Davis, Robert W ..... 446
Hatelid, Frank Hale ..... 136
Ho, Robert Pak Chon ..... 327
Shimokawa, Edward T ..... 46
Tahara, Charles Takeshi ..... 224
Yanagi, Glenn Noriyaki ..... 47
Otitis media, intracranial complications of, in this antibiotic era: report of cases ..... 426
Our New President ..... 559
Ovary, cystadeno fibroma of the: report of a case ..... 409

## P

Paradise practice caps 1 sig. take with grain of salt ..... 31
Poetry ..... 35, 114
President's Page ..... 38, 127, 218, 317, 438, 548
Primary aortoduodenal fistula due to rupture of aortic aneurysm ..... 423
Progress in dermatology ..... 34

## R

Report: First National Congress on the socio-economics of health care ..... 543
Rx—Paradise practice caps 1 sig. take with grain of salt ..... 31

## S

Socio-economics of health care, report: First National Congress on ..... 543
Somebody's going to get killed ..... 105
Special report: American Cancer Society, 1966 scientific session ..... 213
Statistical analysis, ten year profile of Hawaii State Hospital, a ..... 201
Surgical advances in Hawaii during the past 25 years ..... 35

## T

Ten year profile of Hawaii State Hospital: a statistical analysis ..... 201
The case against tradition, microbacterioses ..... 301
The relative value studies: fixed conversion vs. customary fees ..... 115
This Is What's New ..... 43, 131, 221, 321, 441, 551
Thoracic aorta, decleration injury of the ..... 312
Tracheal and esophageal compression, complete vascular ring as the cause of, review or the literature and report of a case ..... 412
Tribute to Harry Loren Arnold, Jr. on the 25th Anniversary of the HAWAII MEDICAL JOURNAL 1941-1966 ..... 25
Tumors, hand: A review ..... 403
Typhoid Fever ..... 547

## U

University of Hawaii ..... 555

## V

Vascular ring, complete, as a cause of esophageal and tracheal compression review of the literature and report of a case ..... 412


# Author Index


Abundo, Manuel, Jr ..... 412
Alter, Anthony H ..... 403
Bergin, William N ..... 105
Berry, Ralph ..... 547
Catts, Ann B ..... 418
Chang, Walter W. M ..... 416, 423
Farin, Remedio ..... 531
Faus, Marie ..... 31
Faus, Robert ..... 31
Gudeman, Howard E ..... 201
Haber, Meryl ..... 403
Hartman, William ..... 531
Hobson, G. Campbell ..... 312
Howard, Kajorn Lekhakul ..... 209
Jim, Robert T. S ..... 125
Johnson, Harold M ..... 34
Lal, Amrit ..... 110
Lau, Edward K ..... 435
Lauriault, Claude ..... 125
Lee, Frederick S. F ..... 409
Liu, Gordon ..... 416, 423
Lytle, Hugh ..... 25
Mason, Carl B ..... 312
Miyazawa, Kunio ..... 409
Nance, F. D ..... 303
Pang, Herbert ..... 430
Pang, L. Q ..... 426
Pang, Richard K. S ..... 412, 435
Rosenfeld, John M ..... 207
Schmitt, Robert C ..... 537
Sloan, Norman ..... 213
Strode, Joseph ..... 35
Tamura, Paul ..... 418
Thomas, Robert L ..... 115
West, Rodney ..... 543
Will, Drake ..... 301
Won, William W. T ..... 416, 432
Yokoyama, Mitsuo ..... 121



**INTERNIST,** qualified, age 49, tremendously variegated experience: Internal Medicine and Cardiology—private practice Beverly Hills 15 years, Chief Public Health Advisor USAID Far East, Medical Directorships Litton Industries and MED-COR, owner MED-COR Medical Clinic, U. S. Government and major U. S. industry medical contract experience and current in Internal Medicine and Cardiology fields—desires part-time situation and/or investment. Send details to H. V. Platt, M.D., Director, MED-COR Medical Clinic, P. O. Box 2118, Dublin, California 94566.

**DESIRE TO ACQUIRE**—Medical group, clinic, convalescent center, hospital or other health organization, including paramedical training school. May consider controlling position (investment) solo private practice or industrial operations without altering or disturbing basic operations or personnel. Send details to H. V. Platt, M.D., Director, MED-COR Medical Clinic, P. O. Box 2118, Dublin, California 94566.

*Book Reviews continued from 631*

### Nursing Education Monographs The Hypodermic Injection: A Programmed Unit

*By Elizabeth A. Krueger, 225 pp., $5.00, Teachers College, Columbia University, New York, 1966.*

A PROGRAMMED COURSE for nursing education.

### Your Heart Has Nine Lives

*By Alton Blakeslee and Jeremiah Stamler, M.D., 278 pp., $.75, Pocket Books, Inc., 1966.*

A PAPERBACK which you may desire to recommend to selected patients.

### Annotated Bibliography on Childhood Schizophrenia 1955–1964

*By James R. Tilton, M.S., Marian K. DeMyer, M.D., and Lois Hendrickson Loew, M.S., 136 pp., $3.75, Grune & Stratton, 1966.*

THIS PAPERBACK edition appears to be an excellent compilation of the subject.

### Pediatric Nursing

*By Audrey J. Kalafatich, R.N., M.S.N., 432 pp., $7.00, G. P. Putnam's Sons, 1966.*

A CONCISE GUIDE to good pediatric nursing care.

### The Nursing Clinics of North America, Vol. 1, No. 1

*Subscription runs from March-December, $12.00, W. B. Saunders Company, 1966.*

RECOMMENDED for staff nurses.

### Psychoanalytic Supervision: A Method of Clinical Teaching

*By Jean Flemong, M.D., and Therese F. Benedek, M.D., 252 pp., $6.75, Grune & Stratton, 1966.*

THE PROBLEMS of clinical teaching of psychoanalysis are discussed.

### Medical Secretary's Manual

*By Myreta Eshom, M.A., 506 pp., $8.50, Appleton-Century-Crofts, 1966.*

THIS TEXT is highly recommended for the medical secretary. The shorthand symbols, terminology, and discussions are invaluable for developing a competent and knowledgeable medical secretary.

### Modern Treatment, Vol. 3, No. 4

*Edited by B. J. Kennedy, M.D., and Samuel O. Freedman, M.D., $16.00 per year, July, 1966.*

THIS PARTICULAR VOLUME is highly recommended because of the pertinent articles and special interest in Hawaii of respiratory allergy. Also in this volume is a review of chemotherapy for cancer.

### The History of the Rhode Island Medical Society and Its Component Societies 1812–1962

*276 pp., Roger Williams Press, East Providence, R. I., 1966.*

THE RHODE ISLAND Medical Society is 46 years older than the HMA.

### New Hope for Your Skin

*By Irwin I. Lubowe, M.D., F.A.C.A., 264 pp., $.75, Pocket Books, Inc., 1966.*

A PAPERBACK written for the layman. ■


ISLAND NURSING HOME

*"A Home That Cares"*



CERTIFIED EXTENDED CARE FACILITY

- 24-HOUR SKILLED NURSING CARE
- MEDICAL SUPERVISION—PHYSICAL THERAPY
- CLOSED CIRCUIT TV SUPERVISION
- ALL ROOMS—LIGHT—CLEAN—AIRY
- CONVENIENTLY LOCATED

1205 ALEXANDER ST., COR. OF BERETANIA
PHONE 965-027

MEDICAL PLACEMENT BUREAU and NURSES' REGISTRY

24 HOUR SERVICE

LET US SERVE YOU IN YOUR NEED

Nurses, Staff and Office
Nurses, Private Duty
Nurses, Supervisors
Practical Nurses
Nurses, Aide
Dental Assistants
Physical Therapists
X-Ray Technicians
Laboratory Technicians
Medical Stenographers
Medical Clerks
Receptionists
Male Nurses
Bookkeepers
Home Companions

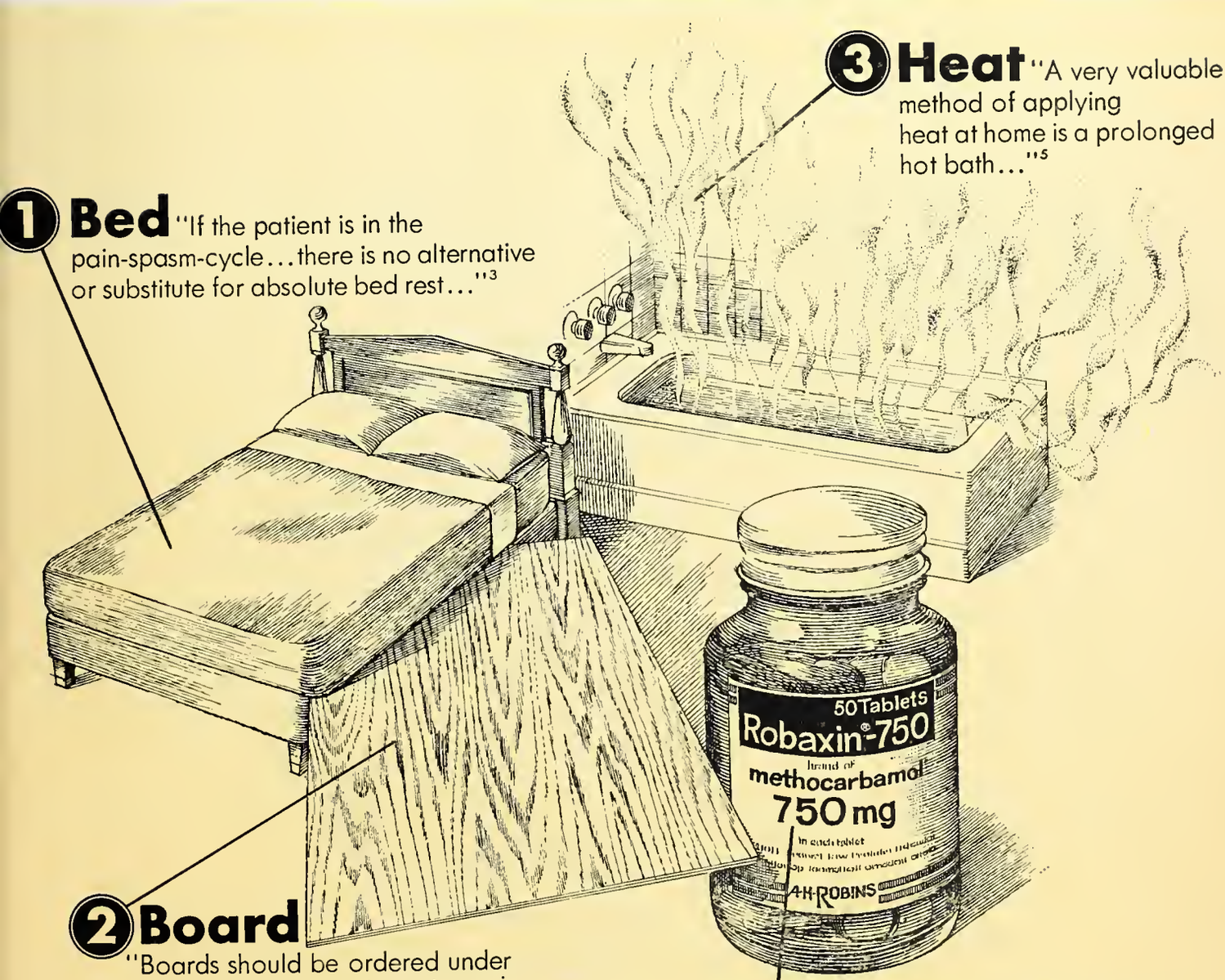
Frieda M. Beezley, R.N., *Director*

1473 South King St. 991-237

# LOW-BACK PAIN

## A CONSERVATIVE, FOUR-POINT PROGRAM

**The low back pain that is most frequently seen in general practice is mechanical in nature, i.e., postural back pain, joint dysfunction and acute back strain.[1,2] For this type of discomfort, a conservative regimen is usually sufficient to relieve aches and pains, and to help keep the patient functioning. Components of this basic program include:**




**1 Bed** "If the patient is in the pain-spasm-cycle...there is no alternative or substitute for absolute bed rest..."[3]

**2 Board** "Boards should be ordered under the mattress...these boards act by immobilizing the spine..."[4]

**3 Heat** "A very valuable method of applying heat at home is a prolonged hot bath..."[5]

**4 Robaxin®-750** (methocarbamol, 750 mg. capsule-shaped tablets) A well-tolerated[6] skeletal muscle relaxant, methocarbamol helps relieve spasm "...without interfering with normal tone and movement."[7] And there is little likelihood of sedation.[6]

**Indicated** for relief of skeletal muscle spasm. **Contraindicated** in hypersensitive patients. **Side Effects** (lightheadedness, dizziness, drowsiness, nausea) may occur rarely, but usually disappear on reduced dosage. Hypersensitivity reactions develop infrequently. See product literature for further details. **Also available:** Robaxin® Tablets (methocarbamol, 500 mg.) Robaxin Injectable (methocarbamol, 1 Gm./10 cc.)

**References:** (1). Godfrey, C.M.: Applied Therap. 8:950, 1966. (2). Gottschalk, L.A.: GP 33:91, 1966. (3). Rowe, M.L.: J. Occup. Med. 2:219, 1960. (4). Cozen, L.: South Dakota J. Med. 18:26, 1965. (5). Soto-Hall, R.: Med. Sc. 14:23, 1963. (6). Weiss, M. and Weiss, S.: J. Am. Osteopath. A. 62:142, 1962. (7). Feuer, S.G., *et al.*: New York J. Med. 62:1985, 1962.

A·H·ROBINS A. H. ROBINS COMPANY RICHMOND, VIRGINIA 23220

# Our "Angels"


| | Page |
|---|---|
| Amfac, Inc. | 629 |
| Ayerst Laboratories | |
| *Demoplast* | 640 |
| Bishop Trust Company | 495 |
| Bristol Laboratories | |
| *Polycillin* | 506, 507 |
| *Tetrex-F* | 527 |
| Burroughs Wellcome & Co. (U.S.A.) Inc. | |
| *Polysporin* | 525 |
| Byron II Steak House | 623 |
| Carnation Co. | 526 |
| Ciba Pharmaceutical Co. | |
| *Doriden* | 630, 631 |
| *Serpasil/Esidrix* | 522, 523, 524 |
| Coca-Cola Bottling Co. of Honolulu | 627 |
| Eastman Kodak Co. | 502, 503 |
| Finance Factors | 497 |
| Financial Management Institute | 628 |
| Geigy Pharmaceuticals | |
| *Preludin* | 504, 505 |
| *Tandearil* | 616, 617 |
| General Diagnostics | |
| *Simplastin* | 613 |
| Hawaii Medical Service Association | 618 |
| Hawaii Shopping Center Corp. | 623 |
| Hawaiian Airlines | 621 |
| Hynson, Westcott & Dunning, Inc. | |
| *Bromsulphalein* | 491 |
| Island Nursing Home | 636 |
| Jelco Laboratories | |
| *Disposable Syringe-Catheters* | Insert (betw. 514 & 515) |
| Lilly, Eli, & Co. | |
| *Co-Pyronil* | 528 |
| *Darvon Compound* | 489 |
| *Ilosone* | 508, 509, 510 |
| *V-Cillin K* | 624, 625, 626 |
| Mead Johnson Laboratories | |
| *Enfamil/Pro-Sobee* | 517, 518, 519 |
| Medical Placement Bureau | 636 |
| New York Life Insurance Co. | 493 |
| O'Leary, Lydia, of Hawaii | |
| *Covermark* | 622 |
| Optical Dispensers of Hawaii, Inc. | 621 |
| Parke, Davis & Co. | |
| *Benadryl* | 490 |
| Physicians Ambulance Service, Inc. | 619 |
| Pitman-Moore | |
| *Novahistine LP* | 520, 521 |
| Platt, H. V., M.D. | 635 |
| Robins, A. H., Co., Inc. | |
| *Ambar* | 496 |
| *Robaxin* | 637 |
| Roche Laboratories | |
| *Librium* | 501 |
| Schuman Carriage Co., Ltd. | |
| *Cadillacs* | 525 |
| Searle, G. D., & Co. | |
| *Flagyl* | 520 |
| Star-Bulletin Printing Co. | 627 |
| Stuart Company, The | |
| *Mylanta* | 500 |
| Summers Prescription Shops | 628 |
| Syntex Laboratories, Inc. | |
| *Norinyl* | 511, 512, 513, 514 |
| Teeny Tots Foot Wear | 515 |
| Williams Mortuary | 615 |
| Winthrop Laboratories | |
| *Phisohex* | 639 |
| Wyeth Laboratories | |
| *Equanil* | 498, 499 |
| *Serax* | 632, 633 |
| *Tubex* | Insert (between 628 & 629) |
| Zale's Jewelers | 516 |



***SPECIAL INTRODUCTORY OFFER ON EDP BILLING SYSTEM!***

**60 DAY TRIAL PERIOD AT NO RISK TO YOU**

***In Addition . . .***

**FREE CONSULTATION ON LIFE-TIME FINANCIAL PLANNING**

* OFFER WILL END SEPT. 30, 1967.




***Financial Management Institute***

*Management Methods For Professional People*

**1150 S. King Street, Suite 704** **Honolulu, Hawaii 96814**

**Phone 514-861**




10 6102

THE LIBRARY
UNIVERSITY OF CALIFORNIA
San Francisco
THIS BOOK IS DUE ON THE LAST DATE STAMPED BELOW

7 DAY LOAN

7 DAY
JUL 15 1974

RETURNED
JUL - 8 1974

7 DAY
MAY 22 1979

RETURNED
MAY 15 1979

15m-6,'73(R1768s4)4315-A33-9

St

224874